

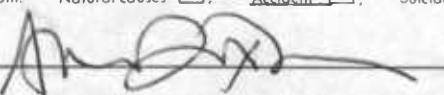
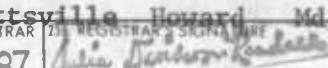
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1B AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 1A. FORM PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1A, 1B, 3 AND 4 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF PUBLIC HEALTH, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, Cremation, OR REMOVAL.

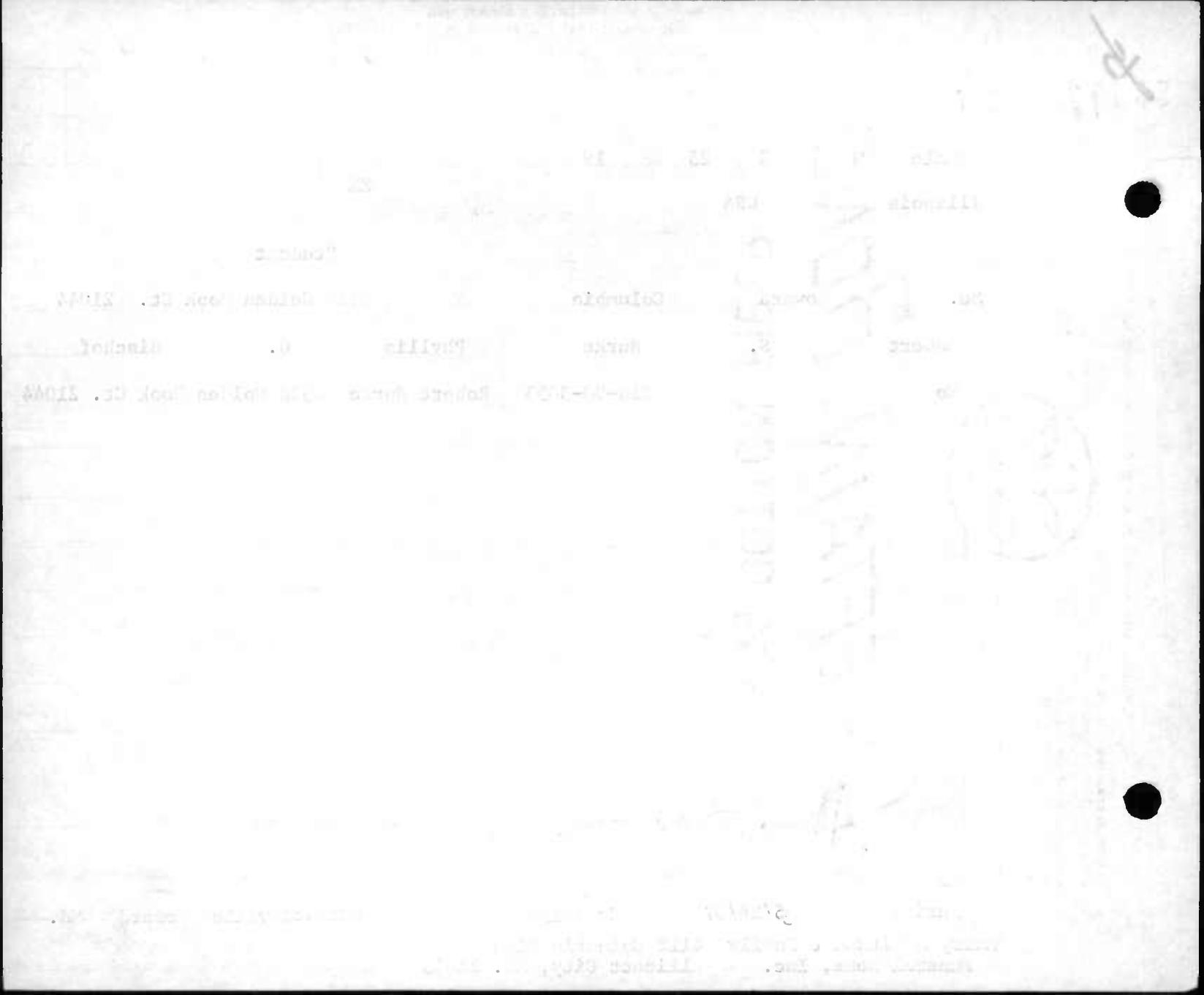
## MEDICAL CERTIFICATION

1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14365

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI. DEATH MATED	MONTH	DAY	YEAR	2b. HOUR	
HEATHER			A.		BURKE	<input checked="" type="checkbox"/>			5 23 1987	M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	9. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR	
Female	W	3 25 68	19 yrs.	MONTHS	DAYS	5 23 1987	1:06				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	11. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH				
Illinois		USA			Dorchester General Hospital		Dorchester County MD				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Cambridge			Dorchester General Hospital			Student					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS				
Md.		Howard		Columbia			6328 Golden Hook Ct. 21044				
14. FATHER'S NAME FIRST			15. MOTHER'S MAIDEN NAME FIRST			16. SOCIAL SECURITY NO.			17. INFORMANT		
Robert			Phyllis			216-90-3053			Robert Burke 6328 Golden Hook Ct. 21044		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Head and neck injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?					
									YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11:35xx 5-23-1987			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver of auto attempting to pass log truck when log went through window.					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road			21f. LOCATION STREET Rt. 50 & MD 16 South			CITY OR TOWN	COUNTY	STATE
									Dorchester, MD		
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE  DATE SIGNED 5-24-87											
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			TITLE (SPECIFY)					
Ann M. Dixon, M.D.			111 Penn St., Balto., MD 21201			M.D. Deputy Chief, MEDICAL EXAMINER					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		STATE
Burial		5/26/87		Crestlawn			Marriottsville, Howard		Md.		
24. FUNERAL DIRECTOR		Harry H Witzke & Family ADDRESS Funeral Home, Inc.			4112 Columbia Pike Ellicott City, Md. 21043			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
								JUN 1 1987			

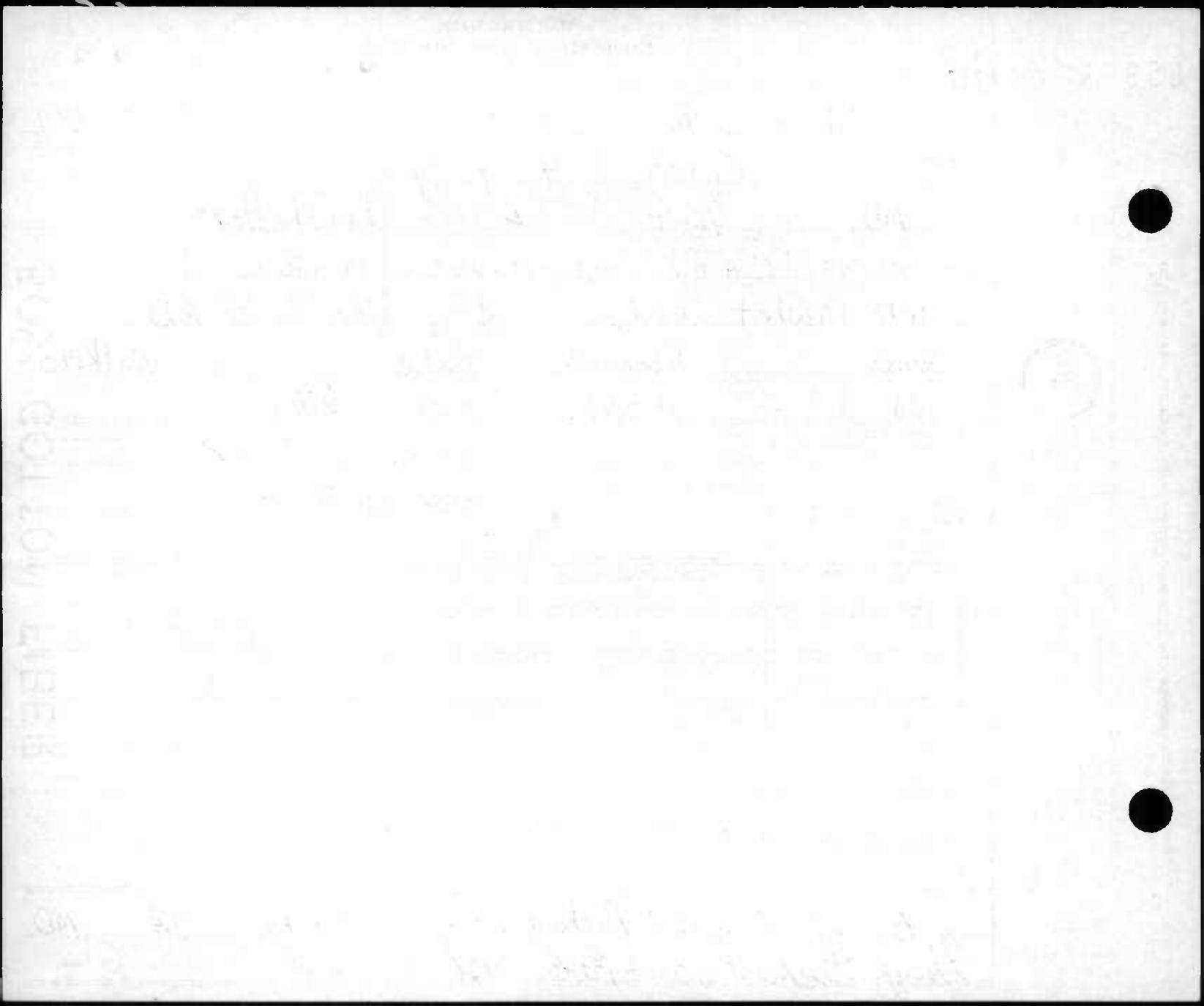


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner shall be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8714366
REG. NO.												
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
Hilda M. Camper						May 7 87			4PM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7		Black		7 7 94			93 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8			9 BALTIMORE CITY OR COUNTY OF DEATH					
MD		USA					Dorchester			MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Cambridge		Cambridge House					Domestic					
13a. STATE MD		13b. COUNTY Talbot		13c. CITY OR TOWN Easton			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 705 Dover RD. 21601		
FATHER'S NAME FIRST James		MIDDLE Tigman		LAST			15. MOTHER'S MAIDEN NAME FIRST Macie			MIDDLE LAST Walker		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. NO		17. INFORMANT 218-30-7359			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
							Cardio-Respiratory arrest					
							DUE TO, OR AS A CONSEQUENCE OF (b)			Possible acute m/		
							DUE TO, OR AS A CONSEQUENCE OF (c)			ASCVS		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>G. Cauffman</i>		22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/12/87			23c. NAME OF CEMETERY OR CREMATORIAL Richardson Cem			23d. LOCATION CITY OR TOWN Easton				
24. FUNERAL DIRECTOR NAME George Dardell		ADDRESS 315 Court St. Easton Md.			25a. DATE REC'D. BY REGISTRAR MAY 13 1987			25b. REGISTRAR'S SIGNATURE Julia Sonderson-Bendee				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and a copy filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certificate should be filed with the death certificate.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

87 14361

1. DECEASED NAME (TYPE OR PRINT)		FIRST PRESTON MIDDLE C.		LAST CANNON		2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Preston		C.		Cannon		May	31	87	12 <sup>46</sup> PM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS MONTHS DAYS HOURS MIN.		
Male	White	MONTH 10 DAY 31 YEAR 92		94						
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		U.S.A.				Dorchester				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Cambridge		Cambridge House N.H.		auto mech.		automotive				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
Maryland		Dorchester		Fishing Ck.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		rural 21634		
14. FATHER'S NAME		LAST		15. MOTHER'S MAIDEN NAME		MIDDLE		LAST		
FIRST JOHN H.		CANNON		FIRST SARAH		KATHERINE		CANNON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
NO		218-05-8405		son		Md. 21634				
Calvert C. Cannon, Box 63, Fishing Ck.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a)										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)										
DUE TO, OR AS A CONSEQUENCE OF										
(c) C.H.F. Pneumonitis										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). ASCVD, COPD										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED		(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS		5-31-87				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION				
burial		6/3/87		Dorchester Mem. Pk.		Airey, Cambridge, Dor. Md.				
24. FUNERAL DIRECTOR NAME		Curran Funeral Home ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
		308 High St., Cambridge, Md. 21613		JUN 3 1987		Julia D. Sanderson				

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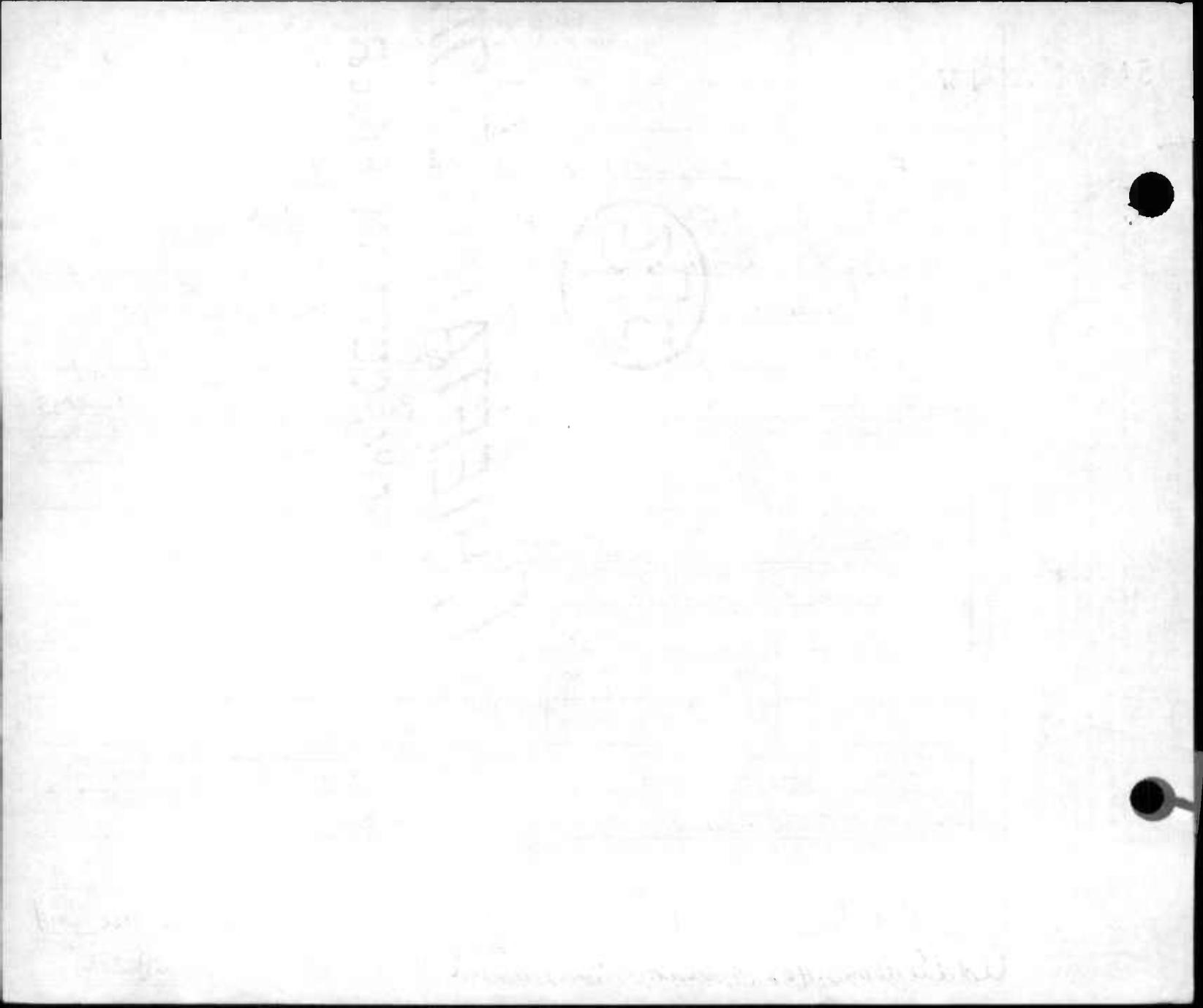
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

certified by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified, fill in by the funeral director, page 3 should be detached for use on the burial permit. Then affix removal or embalming permit with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked an item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8714368	REG. NO.				
1- STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE		LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
		LUVENIA								CORBIN			8	5	11	87	105 P.M.
3. SEX		4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS.			
F		B			MONDAY 6 5 96			90			MONTHS DAYS			HOURS MIN.			
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Md.		USA						Deli			Md.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL RESIDENCE (IF HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			12b. KIND OF BUSINESS OR INDUSTRY			
Cambridge		Cambridge Hosp			Md County			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			Hampdon Ave 21853						
14. FATHER'S NAME FIRST		15. MOTHER'S MAIDEN NAME FIRST			16. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
MISS		ANNA			-			ANNA BIVENS			21853						
18. CAUSE OF DEATH PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cardio-Respiratory Arrest												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause to stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) Possible Acute MI															
		DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
20. MEDICAL CERTIFICATION		21a. DATE OF OPERATION			21b. CONDITION FOR WHICH OPERATION WAS PERFORMED			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTE MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21d. LOCATION STREET			CITY OR TOWN			COUNTY STATE			
21e. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>																	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE		22c. DEGREE			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED									
22f. PHYSICIAN'S NAME (TYPE OR PRINT)		22g. ADDRESS															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY/TOWN			23e. COUNTY			23f. STATE			
Burial		5/16/87			Sotah Wesley			Baltimore			Md			Md			
24. FUNERAL DIRECTOR NAME		25a. ADDRESS			25b. DATE REC'D. BY REGISTRAR			25c. REGISTRAR'S SIGNATURE									
Addil James H. 407 Somerset Princess Anne Md		21853			MAY 28 1987			Julia Jordan-Lindsey									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as 'No' item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.									
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST PAUL			MIDDLE Matthew			LAST Creighton			2a. DATE OF DEATH MONTH MAY	DAY 287	YEAR 1987	2b. HOUR 9 AM			
3. SEX M			4. RACE White			5. DATE OF BIRTH MONTH 03			DAY 15			YEAR 1902			6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS		IF UNDER 1 YEAR MONTHS 0		IF UNDER 24 HRS DAYS 0		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED MARRIED <input checked="" type="checkbox"/>			NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/>			DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester			
10. CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cambridge House			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mariner-Merchant			12b. KIND OF BUSINESS OR INDUSTRY Marine												
13a. STATE Md.			13b. COUNTY Dor.			13c. CITY OR TOWN Cambridge			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 412 Glenburn Ave. 21613									
14. FATHER'S NAME FIRST Beverly			MIDDLE Frank			LAST Creighton			15. MOTHER'S MAIDEN NAME FIRST Laurena			MIDDLE			LAST Aaron						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 217-14-3666			17. INFORMANT Elia Horner			ADDRESS POB 244 Cambridge Md.												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Weeks									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b)																					
DUE TO, OR AS A CONSEQUENCE OF (c)																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE								
22a. I certify that (1) (this hospital) attended the deceased from <u>8/20/87</u> to <u>5/2/87</u> , to <u>5/2/87</u> , that (1) (we) last saw the deceased alive on <u>4/28/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 5/2/87									
22b. SIGNATURE <i>B. J. Alcliffe</i>			22d. DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>															
22e. ADDRESS 408 BYRN ST. CAMBRIDGE MD.																					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE 5/5/87			23c. NAME OF CEMETERY OR CREMATORIAL DOR. MEM. PARK			23d. LOCATION CITY OR TOWN CAMBRIDGE			CITY OR TOWN DOR. MD.		COUNTY							
24. FUNERAL DIRECTOR NAME Thomas Funeral Home			ADDRESS Cambridge			25a. DATE REC'D. BY REGISTRAR MAY 7 1987			25b. REGISTRAR'S SIGNATURE <i>John W. Anderson</i>												



5  
055139 JUN 1 267  
1 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

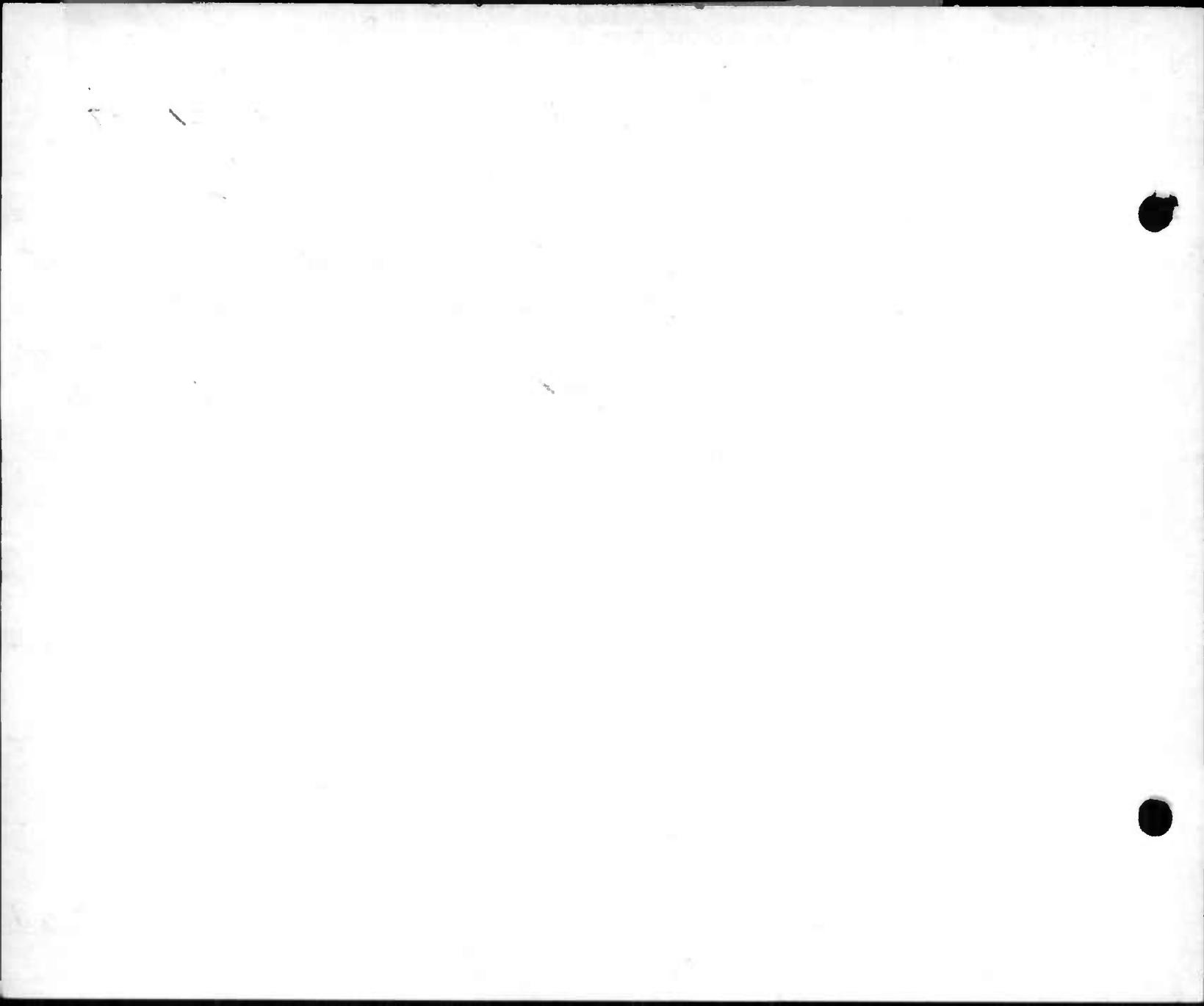
CERTIFICATE OF DEATH 8 / 1 / 4370

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)			First	Middle	Last	20. DATE OF DEATH Month Day Year	26. HOUR
Clarence Edward Davis Jr.						5-21-1987	M
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (In years last birthday)	
male		Black	10-30-1935			51 yrs.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		9. COUNTY OF DEATH	
Md.		U. S.		<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED		Dorchester	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	
Hurlock			P. O. Box 353 Petersburg Md.			Machine	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13c. CITY OR TOWN			13b. KIND OF BUSINESS OR INDUSTRY	
Md.			Dorchester			Dupont	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME	
Charlie					Davis	Mary Jackson	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT	
no			214-349-1138			Geneva Davis P. O. Box 353 Hurlock, Md.	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Ca of Sinos</u>							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
					<input type="checkbox"/> YES <input type="checkbox"/> NO		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION	Street or R.F.D. No.	City or Town	County State
22a. I certify that (1) (this hospital) attended the deceased from 4-28, 1987 to 2-19, 1987, that (1) (we) last saw the deceased alive on 3-19, 1989, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>M. J. Facklen MD</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> DATE SIGNED 5-27-87							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
Michael J Facklen MD		302 Collins Hurlock MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION (City or Town) (County) (State)	
Burial		5-25-87 Petersburg				Petersburg Dorchester Md.	
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Bernie L. Smith		P. O. Box 9-28 Hurlock, Md.				DATE JUN 1 1987 Julia Davidson, R.N.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial permit. Then please remove carbon paper, fold it and send it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked  then 18 shows any injury, or other traumatic event

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8714371	REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
Mney			A.	Eddy		5	5	87	750 PM			
1. SEX	4 RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR			IF UNDER 24 HRS			
Female	Black	MONTH DAY YEAR Jan. 13, 1942			45	YEARS	MONTHS	DAYS	HOURS MIN.			
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
Federalsburg, Md.		U.S.A.					Dorchester MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Cambridge		Dorchester General Hospital			Food processor				Con Agra Co.			
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		14. STATE 14a. COUNTY			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
Maryland		Caroline			NO			Rt. 2, Box 194B 21655				
15. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
George Leonard Johnson			Esther Johnson									
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
No			219-36-6594			Zack Eddy, Rt. 2, Box 194B, Preston,			Md. 21655			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Non Cachexogenic Pulmonary Edema</i>												
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinoma of the Lung</i>												
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Generalized Carcinomatosis</i>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Sever lower extrem lymphedema</i>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from 5-21-1987 to 5-5-1987, that (2) (we) lost saw the deceased alive on 5-5-1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death.										22c. DATE SIGNED		
22b. SIGNATURE <i>Michael J. Fielden MD</i>										DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			23d. LOCATION CITY OR TOWN			23d. LOCATION CITY OR TOWN				
Michael J. Fielden MD		302 Collins, Harlock Ave 21643			Federalsburg, Caroline, Md.			Federalsburg, Caroline, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		23e. DATE REC'D. BY REGISTRAR		23b. REGISTRAR'S SIGNATURE		
Burial		May 9, 1987		Federal Hill Cem.		Federalsburg, Caroline, Md.		MAY 12 1987		Julia S. S. [Signature]		
24. FUNERAL DIRECTOR NAME		ADDRESS			24a. DATE REC'D. BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
Grampston - Hawkins 21671 Main St. Federalsburg, Md.		21632										

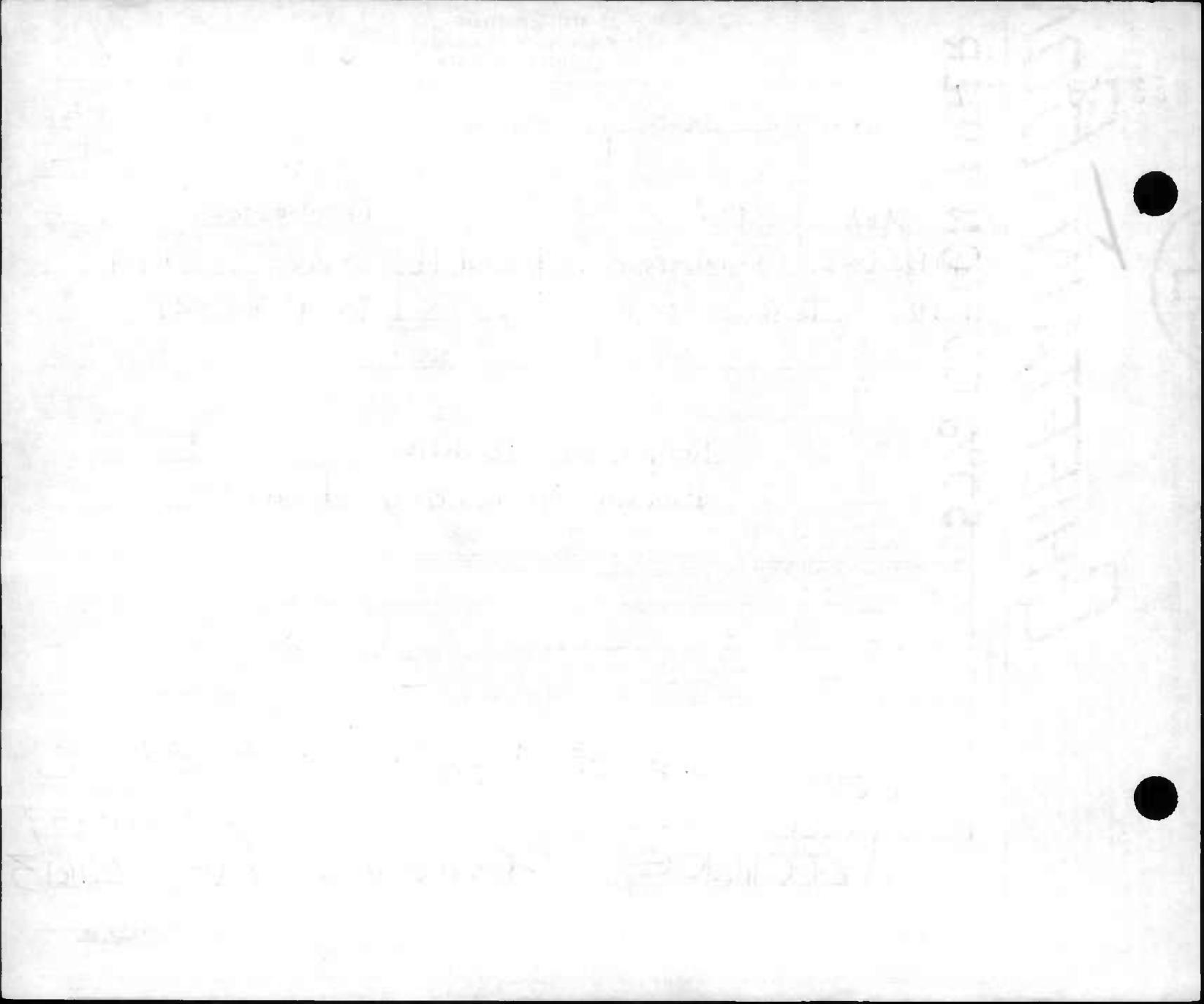


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transt permit. Then please remove carbon paper. Page 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 states any injury, or other traumatic event, a medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8714372	REG. NO.	
1 - STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR		
			William Henry Faulkner						05 10 87			8 1/4 AM		
3 SEX			4 RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
Male			White			12 07 1916			70 YRS.					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Maryland			USA						Dorchester					
CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
CAMBRIDGE			Dorchester General H. Hospital			Wire Rep'th			N/A					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		
MD			Dor.			Cambridge			YES			Rt 4 BX 21 21613		
14. FATHER'S NAME			LAST			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT		
Raymond			Faulkner			Mary			214-07-7632			Marie H. Faulkner		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			16c. ADDRESS			16d. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Yes WW II						Cambridge, Md.								
18. CAUSE OF DEATH Enter only one cause per line for 1a, 1b, and 1c. PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			18b. RESPIRATORY FAILURE.											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)			DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC PULMONARY DISEASE											
18c. DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on above, (I) (we) did not view the body after death.			5.10 87			3.29 19 87			19 87			5.10 19 87		
22b. SIGNATURE						DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			A. WILCE			22e. ADDRESS			400 Maryland Ave 21613			5.10.87		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			23e. COUNTY STATE		
Burial			5/12/87			E. New Mkt Com.			E. New Mkt. Bldg. Md.					
24. FUNERAL DIRECTOR NAME			ADDRESS			25. DATE REC'D. BY REGISTRAR			25b. DATE REC'D. BY CLERK					
THOMAS FUNERAL HOME CAMBRIDGE, MD.						MAY 12 1987								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certificate section must be completed.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				87 14373 REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)		FIRST Leon	MIDDLE Winfield	LAST Fitzhugh	2a DATE OF DEATH MONTH DAY YEAR 5-24-87 0049 AM	2b HOUR
3. SEX MALE	4. RACE White	5. DATE OF BIRTH MONTH 03 DAY 12 YEAR 15		6. AGE (IN YEARS LAST BIRTHDAY) 72	IF UNDER 1 YEAR MONTHS YRS	IF UNDER 24 HRS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester Co. MD.		
10. CITY OR TOWN OF DEATH Cambridge	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) County Employee Retired		
13a. STATE Maryland	13b. COUNTY Dorchester	13c. CITY OR TOWN Church Creek	13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/> XX	13e. STREET ADDRESS / ZIP CODE P.O. Box 56 21622		
14. FATHER'S NAME FIRST John	MIDDLE A.	LAST Fitzhugh	15. MOTHER'S MAIDEN NAME FIRST Leila	MIDDLE	LAST Goslin	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. WW II	16c. INFORMANT Tiny J. Fitzhugh Item # 13	ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr		
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Small cell lung cancer</u>				3 months		
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Brain Metastases</u>						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>87</u> , to <u>24 May</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>23 May</u> , 19 <u>87</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Craig W. Caldwell</u>	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>27 May 87</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CRAIG W. CALDWELL	22e. ADDRESS DORCHESTER GENERAL HOSP. (CAMBRIDGE, MD)					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5/27/87	23c. NAME OF CEMETERY OR CREMATORIAL Dor. Mem Park	23d. LOCATION CITY OR TOWN Cambridge Dor. Md.	23e. COUNTY	STATE	
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME CAMBRIDGE, MD.	25a. DATE FILED BY REGISTRAR MAY 27 1987					
25b. REGISTRAR'S SIGNATURE Leila Caldwell						



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

## TO HOSPITAL OR ATTENDING PHYSICIAN: The

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 4 should be retained for 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DHMH - 16 60M 7/B4  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8714374  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>NETTIE LEVENIA FOXWELL</b>				2a. DATE OF DEATH <b>5 4 87</b>	MONTH <b>3 A M</b>	DAY <b>3 A M</b>	YEAR <b>3 A M</b>	2b. HOUR <b>3 A M</b>	
3. SEX <b>FEMALE</b>	4. RACE <b>CAU.</b>	5. DATE OF BIRTH MONTH <b>Jan.</b> DAY <b>30</b> YEAR <b>1922</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b>	IF UNDER 1 YEAR MONTHS <b>YRS.</b>		IF UNDER 24 HRS HOURS <b>MIN.</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>DORCHESTER MD.</b>						
10. CITY OR TOWN OF DEATH <b>CAMBRIDGE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>DORCHESTER GENERAL HOSP.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>assembly line</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Industrial</b>			
13a. STATE <b>MARYLAND</b>				13b. COUNTY <b>DORCHESTER HURLOCK</b>		13c. CITY OR TOWN <b>Rt. 2, Box 79</b>		21643	
14. FATHER'S NAME FIRST <b>JAMES</b> MIDDLE <b>W.</b> LAST <b>ROBBINS</b>				15. MOTHER'S MAIDEN NAME FIRST <b>MINNIE</b> MIDDLE <b>L.</b> LAST <b>HALL</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>219-05-5685</b>		17. INFORMANT <b>husband</b>		ADDRESS <b>ROBERT C. FOXWELL, same as 13e</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Ca of throat</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____									
DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <i>COPD, CHF</i>									
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 _____, to _____, 19 _____, that (I) (we) last saw the deceased alive on _____, 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>G. Curran</i>		DEGREE <b>M.D.</b>			ATTENDING PHYSICIAN	MEDICAL DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>5-5-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>G. Curran</b>				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>	23b. DATE <b>5/6/87</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Dorchester Mem. Pk.</b>			23d. LOCATION CITY <b>Oxon Hill</b> COUNTY <b>Md.</b>	23e. REGISTRAR'S SIGNATURE <b>Airey, Cambridge, Dor.</b>			
24. FUNERAL DIRECTOR NAME <b>Curran Funeral Home, 308 High St. Cambridge, Md. 21613</b>	25a. DATE REC'D. BY REGISTRAR <b>MAY 8 1987</b>	25b. REGISTRAR'S SIGNATURE <b>Julia Sanders-Ladree</b>							

16

16

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked  show any injury, or other traumatic event, the medical examiner will be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												87	14375																
												REG. NO.																	
1. STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST NELLIE			MIDDLE A.			LAST GOTI			2. DATE OF DEATH			MONTH 5			DAY 31			YEAR 87			2b. HOUR 0915 AM		
3. SEX F.			4. RACE Caucasian			5. DATE OF BIRTH MONTH 11 DAY 25 YEAR 00			6. AGE (IN YEARS LAST BIRTHDAY) 86			7. IF UNDER 1 YEAR MONTHS 0 YRS 0			8. IF UNDER 24 HRS MONTHS 0 DAYS 0 HOURS 0 MIN 0														
7a. BIRTHPLACE COUNTRY MD			7b. CITIZEN OF WHAT COUNTRY USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester			10. USU. OCCUPATION (TYPE OF WORKING LIFE) HOMEMAKER			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION NOT IN SUCH FACILITY, GIVE STREET ADDRESS CATHEDRAL DORchester General			12b. KIND OF BUSINESS OR INDUSTRY											
13a. STATE MD			13b. COUNTY DOR			13c. CITY OR TOWN Secret			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 148 Main Sr 2 K64			14. FATHER'S NAME FIRST SAMUEL MIDDLE SPEEDEN LAST ABEY			15. MOTHER'S MAIDEN NAME FIRST BERTHA MIDDLE			LAST SEYMOUR								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 222-16-0155			17. INFORMANT AUDREY M. MOXEY, SECRETARY, MD			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Probable ischemic /infarcted bowel 24 h. DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)			19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
20. MEDICAL CERTIFICATION			19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20b. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) —								
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)			21f. LOCATION STREET — CITY OR TOWN — COUNTY — STATE —																							
22a. I certify that (1) (this hospital) attended the deceased from 5.31.87 to 5.31.87, and that (2) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) we did (2) did not view the body after death.			22b. SIGNATURE NELLIE			22c. DEGREE			22d. DATE SIGNED 5.31.87																				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARWILLE			22e. ADDRESS 400 Maryland Ave 21613			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 6-3-87			23c. NAME OF CEMETERY OR CREMATORIAL OUR LADY OF GOOD COUNSEL, SECRETARY, DOR, MD			23d. LOCATION CITY OR TOWN — COUNTY — STATE —																				
24. FUNERAL DIRECTOR NAME ZELLER FUNERAL HOME, EAST NEW MARKET, MD			25a. ADDRESS			25b. DATE REC'D. BY REGISTRAR 10 1987			25b. REGISTRAR'S SIGNATURE via Gordon Lender																				

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Page 4 may be

relinquished by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8714376			
1- STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Ellen Gertrude Gray						May 22, 1987						10 P M	
3. SEX female			4. RACE white			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			July 20, 1894			7c. 92 YRS			IF UNDER 24 HRS	
10. CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 127 Vue de L'eau St.			12a. USUAL OCCUPATION 12b. KIND OF BUSINESS OR INDUSTRY teacher-public schools			12c. STREET ADDRESS / ZIP CODE 127 Vue de L'eau 21613				
13a. STATE Md.			13b. COUNTY DOR.			13c. CITY OR TOWN Cambridge			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. ADDRESS 121 Vue de L'eau	
14. FATHER'S NAME FIRST MIDDLE LAST Milton Dashiell						15. MOTHER'S MAIDEN NAME Adelaide Naltner						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 YEARS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 217-36-2958			17. INFORMANT John P. Mende			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE			ADDRESS Cambrdige Md. 21613	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			(b)			DUE TO, OR AS A CONSEQUENCE OF							
			(c)			DUE TO, OR AS A CONSEQUENCE OF							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY STATE		
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from 3-16 1987, to 5-22 1987, that <input type="checkbox"/> (we) last saw the deceased alive on 5-14 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) (did) did not view the body after death.													
22b. SIGNATURE Michael A. Moskiewicz MD			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 5-26-87				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL A. MOSKIEWICZ MD			22e. ADDRESS 503 BYRN ST CAMBRIDGE MD 21613										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE 5/25/87			23c. NAME OF CEMETERY OR CREMATORIAL Christ Churchyard			23d. LOCATION CITY OR TOWN Cambridge Dor. Md.			25a. DATE RECEIVED BY REGISTRAR BY REGISTRAR'S SIGNATURE MAY 26 1987	
24. FUNERAL DIRECTOR THOMAS FUNERAL HOME CAMBRIDGE MD.													



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then page number eight (8) and 2 should be filled with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. Certification for removal of body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8714371	
										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Arthur Steart Haring						05	07	87	1:30A.M.		
3. SEX		Male	4. RACE		White	5. DATE OF BIRTH		MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)
						11	09	14		72	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		MD	7b. CITIZEN OF WHAT COUNTRY?		USA	8.		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester Co. MD.		
10. CITY OR TOWN OF DEATH		Cambridge	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		Dorchester General	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE		MD	13b. COUNTY		Dorchester	13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE 403 Light St. 21613			
14. FATHER'S NAME		Arthur	MIDDLE	Edwin	LAST	15. MOTHER'S M AIDEN NAME		16. ADDRESS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		214-07-9652	17. INFORMANT		Doris W. Haring Item 13			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Had Transurethral resection of prostate 5/6/87											
19a. DATE OF OPERATION 5/6/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Enlarged prostate		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5-04-87, 19, to 5-07, 19, 87, that (I) (we) last saw the deceased alive on 5-07, 19, 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Raul Diaz</u>		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/7/87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Raul Diaz, M.D.		22e. ADDRESS 200 Maryland Ave. Cam									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/9/87		23c. NAME OF CEMETERY OR CREMATORIAL Dor. Mem. Park		23d. LOCATION CITY OR TOWN Cambridge Dor. Md.					
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME CAMBRIDGE, MD.		ADDRESS		25a. DATE REC'D. BY REGISTRAR MAY 11 1987		25b. REGISTRAR'S SIGNATURE Julia Gordon-Rudner					

Engines - tools and

5000 ft. 1100 ft. 400 ft.

redundant

400 ft. 400 ft.

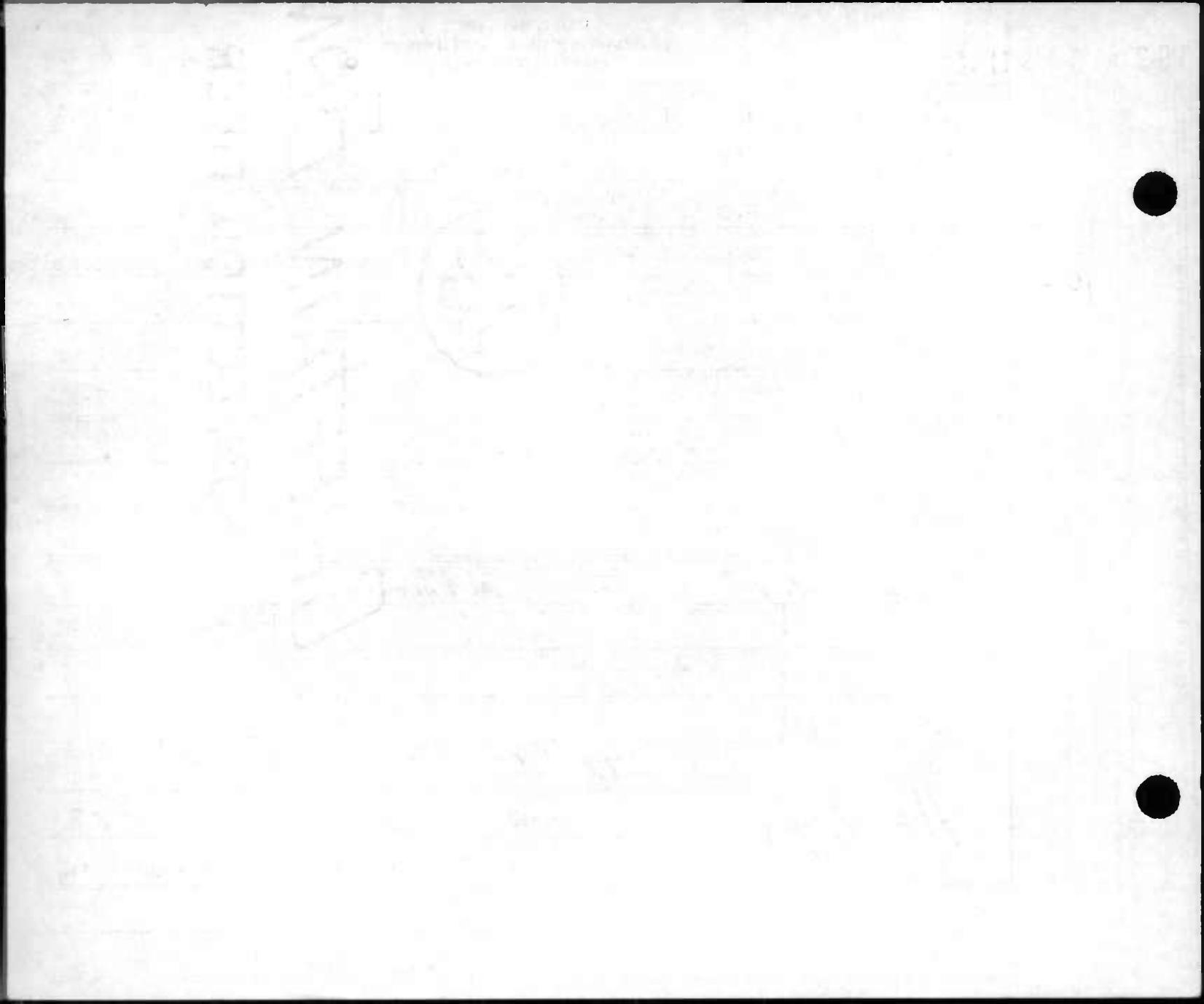
1000 ft. 1000 ft. 1000 ft.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transport permit. Then please remove carbon paper. Pages 4 and 2 should be used within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "I" (I certify)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8714378	REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			20. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
ARTHUR Q. Johnson						5/15/87			10:50 A.M.				
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 9 24 98			6. AGE (IN YEARS LAST BIRTHDAY) 88		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.						
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) boatyard/marine construction			12b. KIND OF BUSINESS OR INDUSTRY						
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md.		13b. COUNTY Dor.		13c. CITY OR TOWN Cambridge			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 804 Maryland Ave. 21613				
14. FATHER'S NAME FIRST MIDDLE LAST George Thomas Johnson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Ann Sinclair										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212-12-4111		17. INFORMANT Mary T. Johnson			ADDRESS 804 Maryland Ave Cambridge Md. 21613						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PARKIN'SONISM</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Year</u>			
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>ATE REVER FAILURE, ALZHEIMER'S</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>5/15</u> , 19 <u>87</u> , to <u>5/15</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>5/15</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and I am the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>H.C. AYERS</u>										22c. DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. DATE SIGNED <u>5/15/87</u>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 5/7/87		23c. NAME OF CEMETERY OR CREMATORIAL DOR. MEM. PARK			23d. LOCATION CITY OR TOWN CAMBRIDGE DOR. MD.						
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME ADDRESS CAMBRIDGE MD.										25a. DATE REC'D. BY REGISTRAR MAY 8 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Dawson-Lindner</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

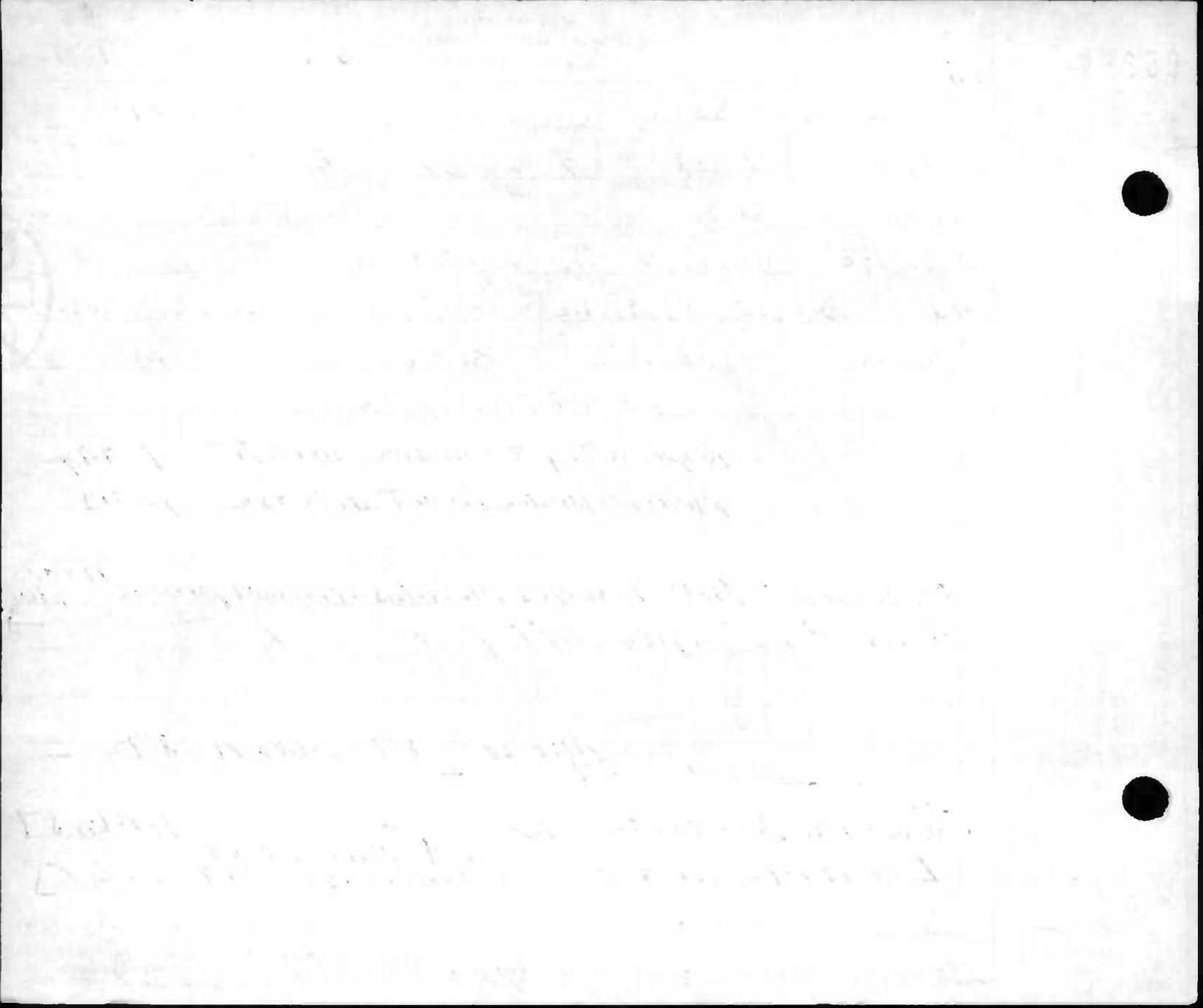
retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be held within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked  it shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										87 14379	REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR													
James Sebon Johnson						05 11 87			M													
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.										
Male		Black		7 22 07			85 79 yrs															
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			10 CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
N.C.		U.S.					Dorchester			Cambridge				Dorchester Gen Hospital			Retired			MD		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE Schoolhouse Lane 21613			14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Md.		Dorchester		Cambridge			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						Douglas				Betty					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c)			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
		217-10-5148					Respiratory & cardiac arrest			1 day												
19a. DATE OF OPERATION + May 87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Gangrene left foot		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Gangrene left foot. Diabetes mellitus. Normal pressure cephal												
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			211. LOCATION STREET CITY OR TOWN COUNTY STATE															
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					211. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that (I) (this hospital) attended the deceased from <u>May 10</u> , 1987, to <u>May 11</u> , 1987, that (I) <input type="checkbox"/> last saw the deceased alive on <u>May 11</u> , 1987, and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did (and did not) view the body after death.		22b. SIGNATURE Lewis M. Burkette M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11 May 87															
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis M. Burkette		22e. ADDRESS 4 Aurora St Cambridge Md 21613																				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/16/87		23c. NAME OF CEMETERY OR CREMATORIAL Bethel Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Cambridge Dorchester Md.															
24. FUNERAL DIRECTOR NAME Stewart Funeral Home Cambridge Md.		ADDRESS		25a. DATE REC'D. BY REGISTRAR MAY 13 1987			25b. REGISTRAR'S SIGNATURE Julia D. Darden															



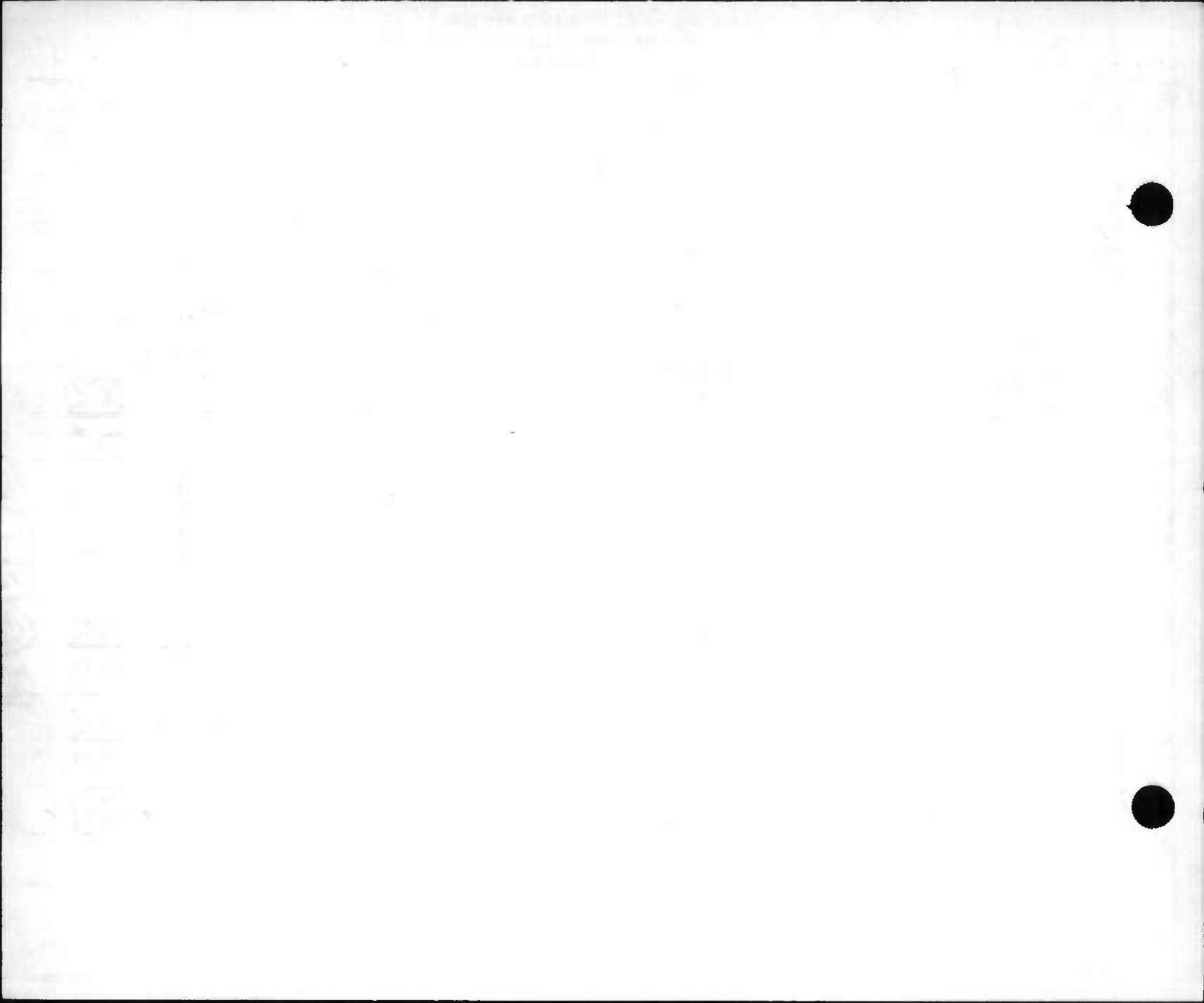
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use on the burial/transit permit. Then please remove carbon paper and attach this page to the burial/transit permit with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, it must be notified of once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
8 7 1 4 3 8 0 REG. NO.													
1 - STATE REGISTRAR			1a DECEASED NAME (TYPE OR PRINT)			1b FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR	
Jesse			Lidden, Jr.			May 17, 1987			7:30AM				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
Male		White		May 1, 1934			53						
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester Co. MD						
Maryland		US											
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Vocational Rehab			12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE Maryland		13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 701 Race St. 21613			
14. FATHER'S NAME Jesse		15. MOTHER'S M AIDEN NAME Lidden		16. SOCIAL SECURITY NO. 220-32-0163			17. INFORMANT Grace H. Kimmey			ADDRESS 219 Henry St. Cambridge, Md. 21613			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CVA Hypertension												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____. that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22e. DATE SIGNED 5-18-87	
22b. SIGNATURE 		22c. DEGREE MD		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN									
22e. PHYSICIAN'S NAME (TYPE OR PRINT) G. C. Kimmey		22f. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/19/87		23c. NAME OF CEMETERY OR CREMATORIAL Unity Washington Cem. Hurlock, Del. Md.			23d. LOCATION CITY OR TOWN			COUNTY	STATE		
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME CAMBRIDGE, MD.		ADDRESS		25a. DATE REC'D. BY REGISTRAR MAY 21 1987			25b. REGISTRAR'S SIGNATURE Julia Sander-Lindbeck						
DHMH - 16 60M 7/B4 (VRA 15, 4)													



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

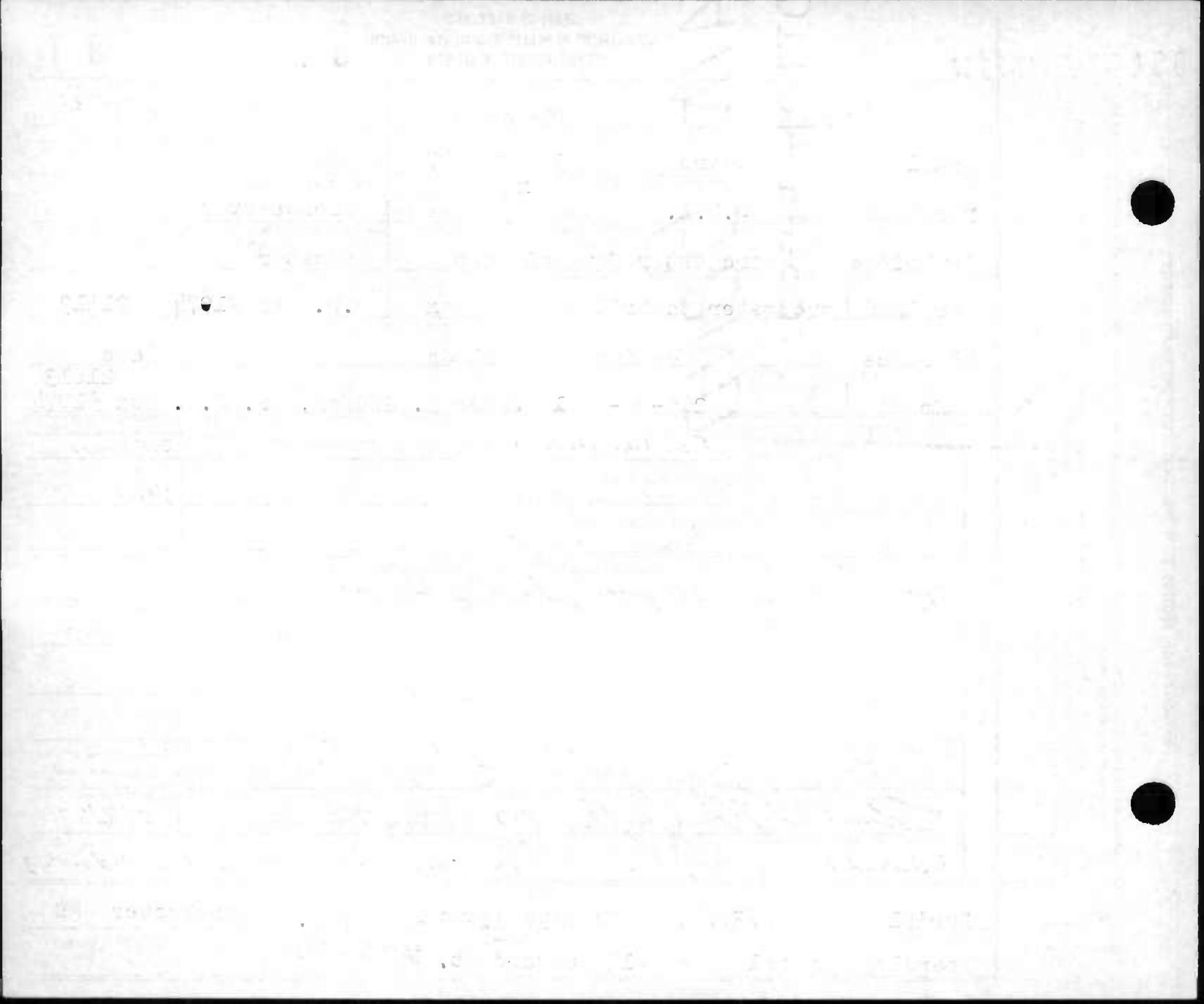
**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death.

**IMPORTANT:** If Item 2 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT) <b>SHIRLEY T MADDOX</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>5 16 87</b>	2b. HOUR <b>5:00 PM</b>
3. SEX <b>Female</b>	4. RACE <b>Negro</b>	5. DATE OF BIRTH MONTH <b>3</b> DAY <b>29</b> YEAR <b>27</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>60</b>	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN. <b>0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester</b>		
10. CITY OR TOWN OF DEATH <b>Cambridge</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Dorchester General Hosp</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Educator</b>	
13. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>				13b. COUNTY <b>Dorchester</b>	13c. CITY OR TOWN <b>Cambridge</b>
14. FATHER'S NAME FIRST <b>Clarence</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Rhoda</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>218-20-8861</b>	17. INFORMANT ADDRESS <b>James M. Maddox, Sr., P.O. Box #1074</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3.5 hours</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Cardiomyopathy</b>				years	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiomyopathy</b>					
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Atherosclerosis</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <b>Hypertension</b> <b>Peripheral Vascular Disease</b>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET	CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from <b>5/16/87</b> to <b>5/16/87</b> , that (we) last saw the deceased alive on <b>5/16/87</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Edmund J. MacLaughlin</b>		DEGREE <b>MD</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>5/16/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Edmund J. MacLaughlin</b>		22e. ADDRESS <b>10 Aurora St. Cambridge, Md 21613</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>5/20/87</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Private Cemetery</b>	23d. LOCATION CITY OR TOWN <b>Camb.</b>	23e. COUNTY <b>Dorchester</b>	23f. STATE <b>MD</b>
24. FUNERAL DIRECTOR NAME <b>Boardley Funeral Home</b>	ADDRESS <b>812 Hubbard St.</b>	25a. DATE REC'D. BY REGISTRAR <b>MAY 19 1987</b>	25b. REGISTRAR'S SIGNATURE <b>Boardley Funeral Home</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed

by the funeral director. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified to the State Dept. of Health and Mental Hygiene, it should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be detached and the first page sent to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

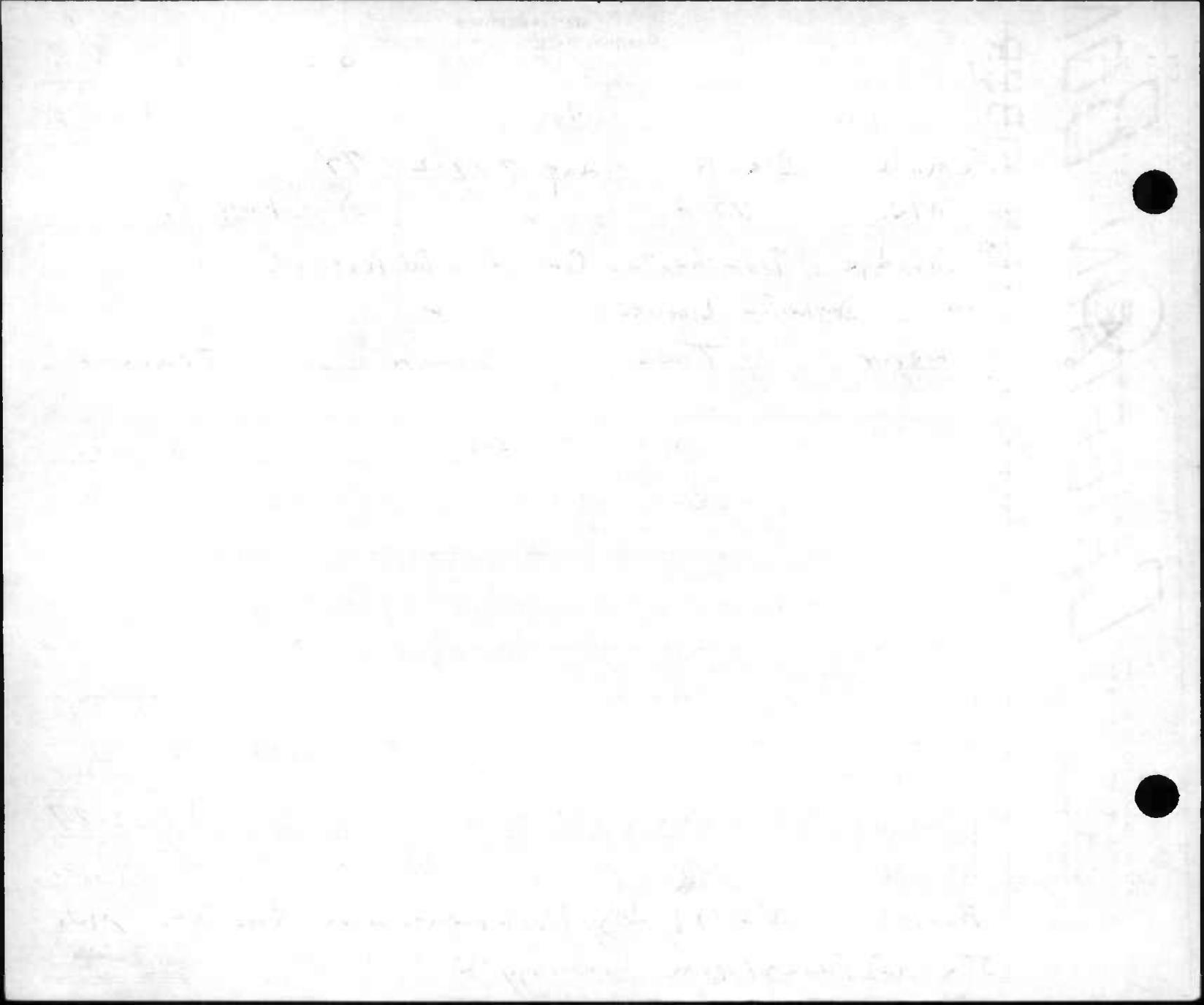
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical

attending physician

should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	7	1	4	3	8	2		
										REG. NO.								
1 - STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
		<i>Rebecca</i>							<i>Matney</i>		MAY		22	1987	4:45 PM			
3. SEX		4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS					
Female		Black			MONTH DAY YEAR			74			YEARS	MONTHS	DAYS	HOURS	MIN.			
7d. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
Md.		U.S. A			Aug 7 1912						<i>Dorchester Co.,</i> MD							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
<i>Cambridge</i>		<i>Dorchester Gen Hospital Retired</i>																
13a. STATE Md.		13b. COUNTY Dorchester			13c. CITY OR TOWN Linen Ridge			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Linen Rd.			ZIP CODE 21613				
14. FATHER'S NAME FIRST <i>Levin</i>		MIDDLE <i>Todd</i>			15. MOTHER'S MAIDEN NAME FIRST <i>Sarah</i>			MIDDLE <i>Travers</i>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks								
<i>HEART FAILURE</i>																		
DUE TO, OR AS A CONSEQUENCE OF (b) <i>LEIOMYOSARCOMA</i> OR STOMACH										6 months								
DUE TO, OR AS A CONSEQUENCE OF (c)																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?										
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>DEC 5-22 1987</i> to <i>5-22 1987</i> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <i>5-22 1987</i> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death.																		
22b. SIGNATURE <i>Michael A. Moskewicz MD</i>										DEGREE ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>								
										22c. DATE SIGNED <i>5-22-87</i>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Michael A. Moskewicz MD</i>										22e. ADDRESS <i>503 BYRN ST. CAMBRIDGE MD 21613</i>								
23a. BURIAL, CREMATION, REMOVAL (IF ANY)		23b. DATE <i>5/27/87</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>John Wesleyene, Linen's Road, Dor. Md.</i>			23d. LOCATION CITY OR TOWN COUNTY STATE										
Burial																		
24. FUNERAL DIRECTOR NAME <i>Stewart Funeral Home</i>		ADDRESS <i>Cambridge, Md.</i>			25a. DATE REC'D. BY REGISTRAR <i>JUN 1 1987</i>			25b. REGISTRAR'S SIGNATURE <i>Julia Dawson-Lindell</i>										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and delivered to you, it should be detached for use as the Burial/Transit permit. Then please remove carbon paper. Page 3 should be detached for use as the Burial/Transit permit. Then please remove carbon paper. Page 4 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified of death.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8714383	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
Carl Samuel McCollister, Sr.						May 24, 1987			6:30PM		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male		White		March 16, 1909			78 YRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		US					Dorchester Co. MD				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Cambridge		Dorchester General Hospital					Farmer				
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Dorchester		13c. CITY OR TOWN Vienna			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Rt 1 Box 116 A 21869		
14. FATHER'S NAME FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Thomas		Allen		Mabel Meyer							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS				
No		217-35-1682		Emma McCollister Item # 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Cardiopulmonary Arrest										acute	
DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac failure / arrhythmia											
DUE TO, OR AS A CONSEQUENCE OF (c) Coronary artery disease										years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b): Pulmonary congestion / Arteriolosclerosis											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY?		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____. that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Reinhardt Sahmel MD										DEGREE ATTENDING MEDICAL STAFF PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 5/25/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Reinhardt Sahmel		Lab. Dorchester Gen. Hosp.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 5/28/87		23c. NAME OF CEMETERY OR CREMATORIAL Dor. Mem. Park			23d. LOCATION CITY OR TOWN Cambridge		COUNTY Dor. Md.		
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME CAMBRIDGE, MD.							25a. DATE REC'D. BY REGISTRAR MAY 28 1987		25b. REGISTRAR'S SIGNATURE John R. Kendall		

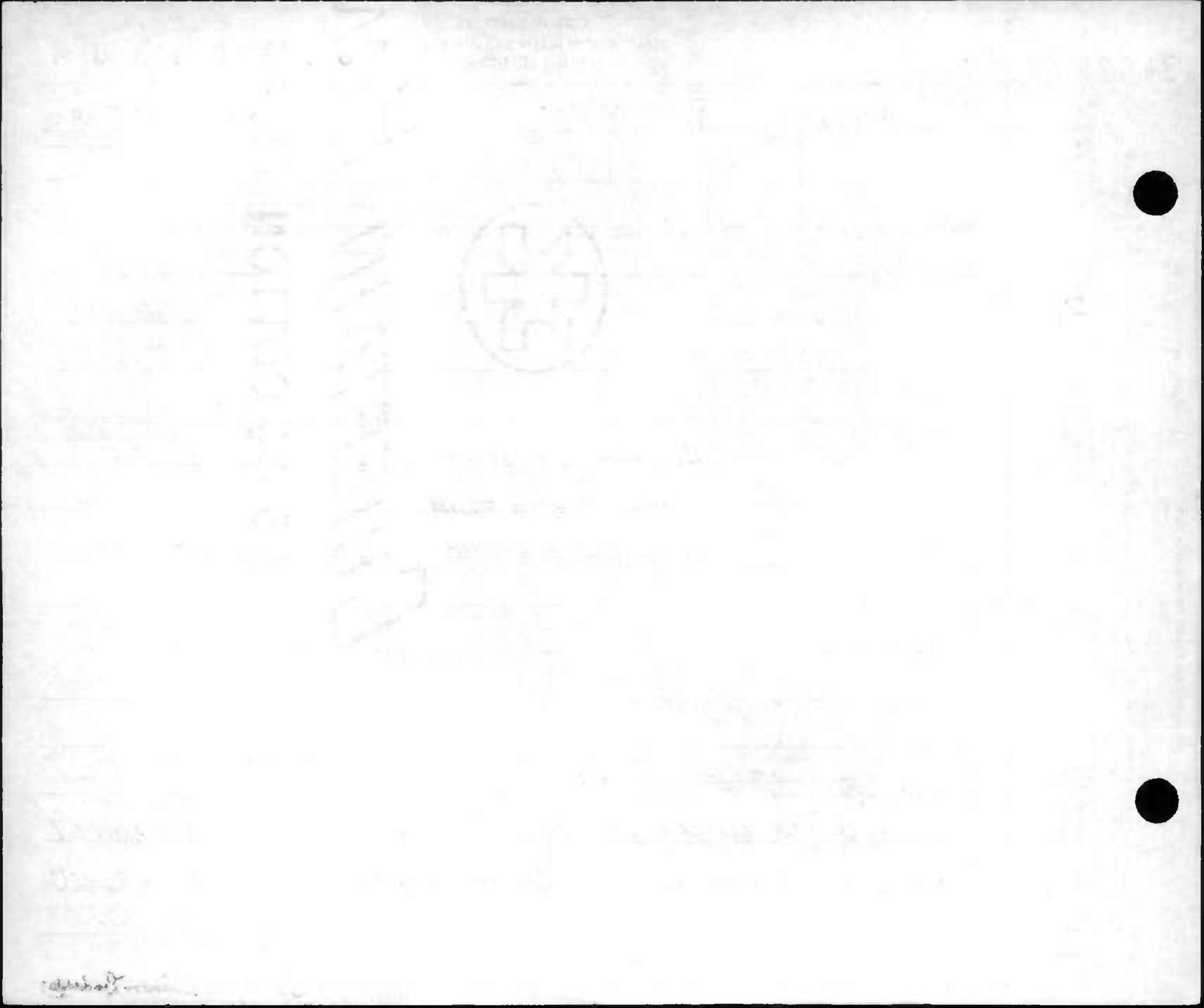


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please remove carbon paper. Pages 1 and 2 may be retained with the burial permit with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18, show any injury, or other causative event, the medical examiner will be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8714384					
FOR STATE REGISTRAR			DATE OF DEATH							REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2d DATE OF DEATH	MONTH	DAY	YEAR	2d HOUR		
HULDAH R. Mills									5-14-87	14384			5:55 PM		
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
female			white		Oct. 12, 1913			73			YRS	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE COUNTRY MD.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester			MD.			
10. CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dor. General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) teacher-public schools			12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE Md.			13b. COUNTY Dor.		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 304 E. Appleby Ave. 21613					
14. FATHER'S NAME			FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME			16. ADDRESS					
Edward			S.		Robinson		Marie			Bayliss					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
NO			219-36-7215			Catherine Robinson Item # 13			70						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u>															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>THROMBOCYTOPENIA</u>										MONTHS					
{ DUE TO, OR AS A CONSEQUENCE OF (c) <u>MULTIPLE MYELOMA</u>										9 YEARS					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. MEDICAL CERTIFICATION			19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
									YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1, OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (1) this hospital attended the deceased from 12 MAY 1987 to 14 MAY 1987, that (1) we last saw the deceased alive on 14 MAY 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) we (did) (did not) view the body after death.															
22b. SIGNATURE <u>Craig W. Caldwell</u>			22c. DEGREE M.D.			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 14 MAY 87						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Craig W. Caldwell</u>			22e. ADDRESS DORCHESTER GENERAL HOSP., CAMBRIDGE, MD												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE 5/17/87			23c. NAME OF CEMETERY OR CREMATORIUM Dor. Memorial Park			23d. LOCATION CITY OR TOWN Cambridge			COUNTY	STATE		
24. FUNERAL DIRECTOR NAME Thomas Funeral Home Cambridge Md.						25a. DATE REC'D. BY REGISTRAR MAY 19 1987			25b. REGISTRAR'S SIGNATURE <u>Patricia B. [Signature]</u>						



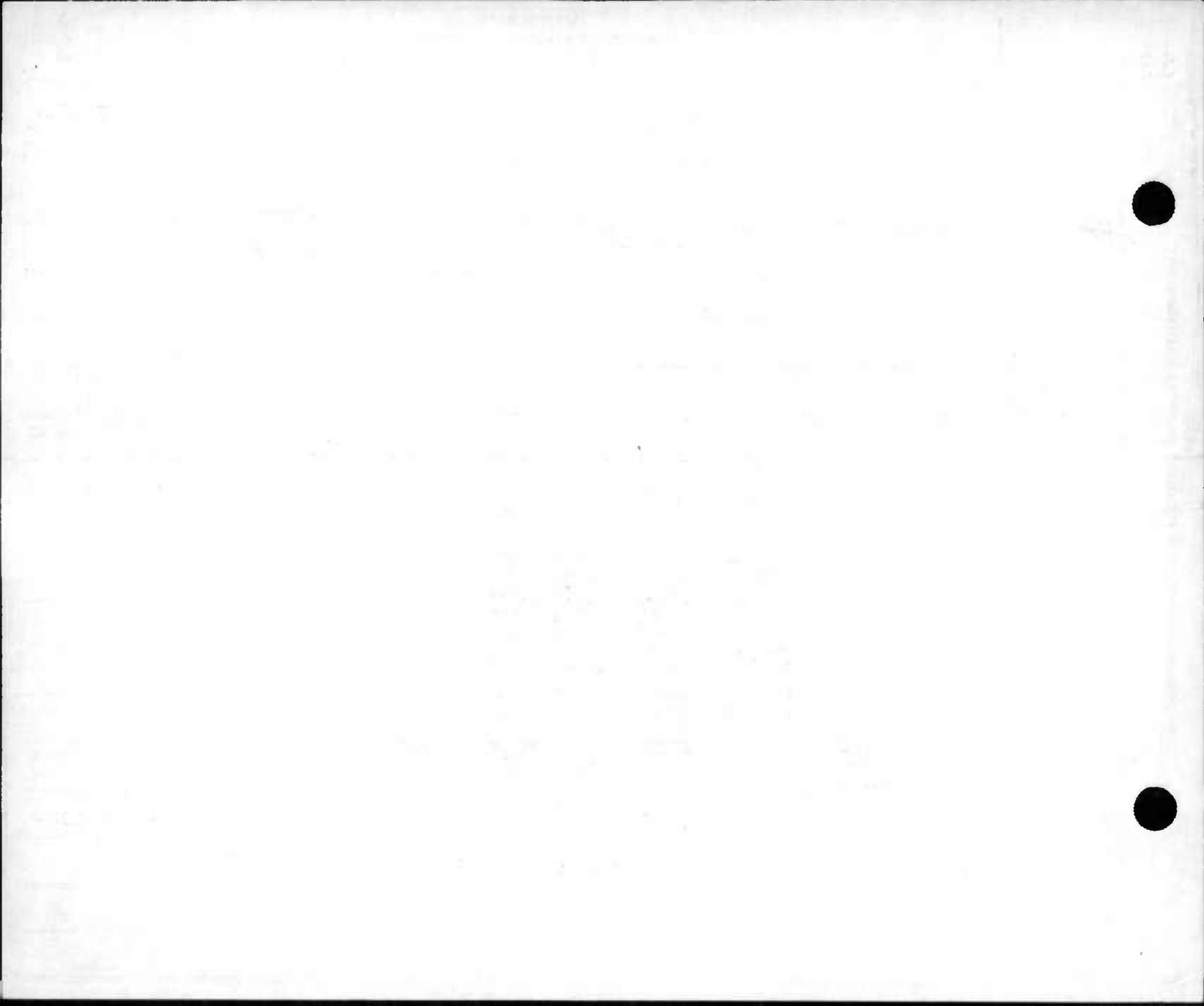
Page 4 may be

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper from pages 1 and 2 and be held until 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 22 shows any injury, or other traumatic event, it must be marked or made available in the death certificate.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1 - STATE REGISTRAR		REG. NO. 8714385									
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST		
Beatrice Brohawn Murphy											
2a. DATE OF DEATH			MONTH			DAY			YEAR		
May 11, 1987											
2b. HOUR											
7:15 PM											
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		
Female			White			MONTH DAY YEAR			IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland			US						Dorchester Co. MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION Homemaker			12b. KIND OF BUSINESS OR INDUSTRY		
Cambridge			110 High Street								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Maryland			Dorchester			Cambridge			13e. STREET ADDRESS / ZIP CODE 110 High Street 21613		
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME			16. ADDRESS		
Charles E. Brohawn						Ada			120 Vue de L'Eau		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES		
No			214-07-9472			Douglas C. Murphy Cambridge, Md.			YEARS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u>											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>OBGS, ATRIAL FIB, AODM</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		
22a. I certify that (I) (We) attended the deceased from <u>3/25</u> , 19 <u>80</u> , to <u>19</u> , 19 <u>87</u> , that (I) (We) last saw the deceased alive on <u>5/2</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did not view the body after death.									COUNTY STATE		
22b. SIGNATURE <u>Hubert L. Fiery Jr.</u>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>5/12/87</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Hubert L. Fiery Jr.</u>			22e. ADDRESS <u>503 BYRN ST</u>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		
Burial			5/14/87			Dor Mem Park			Cambridge Dor Md.		
24. FUNERAL DIRECTOR <u>THOMAS FUNERAL HOME CAMBRIDGE, MD.</u>			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE <u>Julie Gordon-Lindell</u>		
						MAY 13 1987					



053747 MAY 10

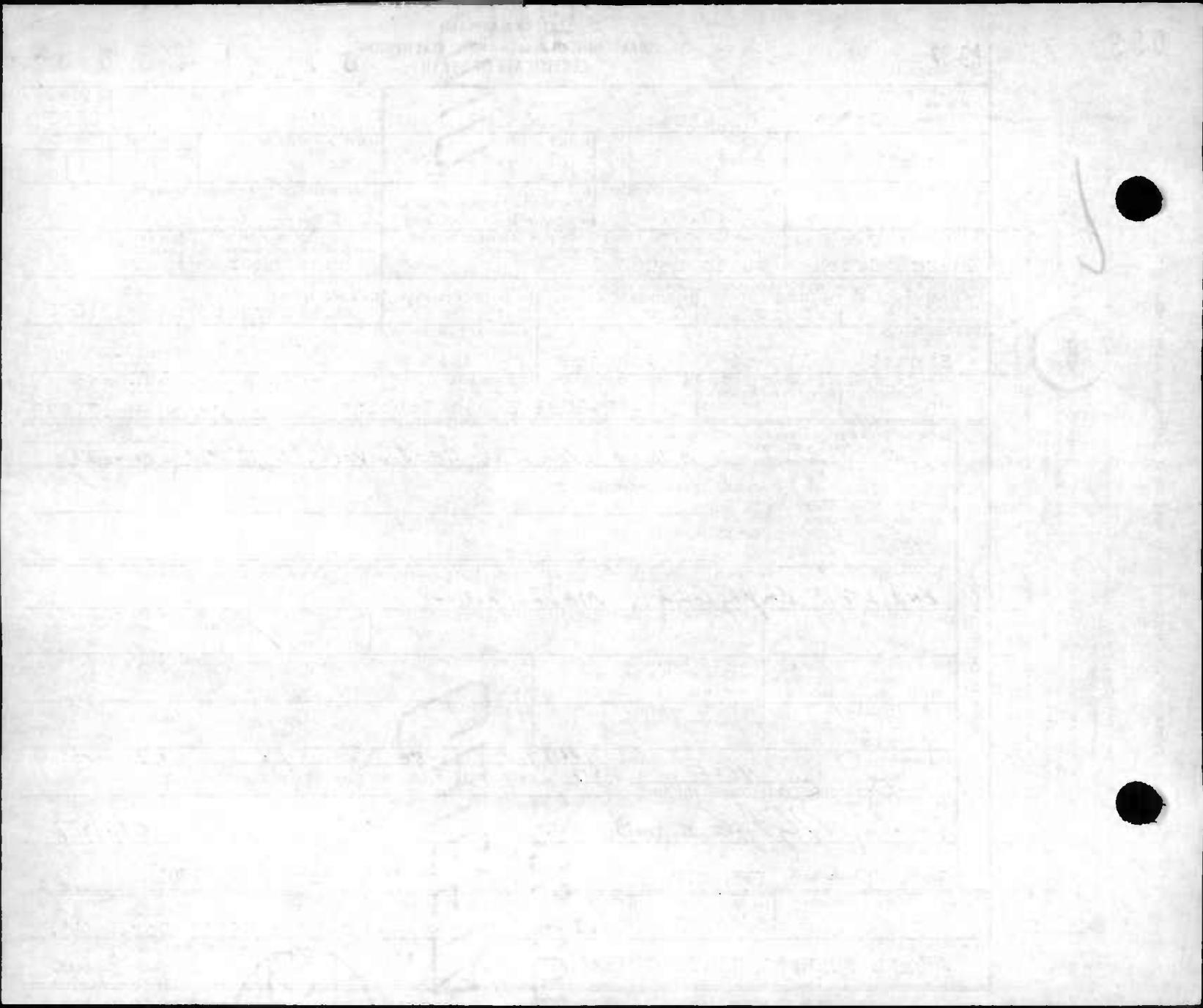
FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8714330  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR			
Grace Kathleen Paul						May 8, 1987				0530 M			
3. SEX		4 RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
female		white	May 21, 1910			76	YRS.	MONTHS	DAYS	HOURS	MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH							
Md.		U.S.A.				Dorchester MD							
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						12b KIND OF BUSINESS OR INDUSTRY		
Church Creek		state route 335			homemaker								
13a STATE		13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET ADDRESS						
Md.		Dor.	Church Creek				state route 335 21622						
14 FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			LAST						
Samuel		Alonzo	Johnson	Susie			Moore						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17 INFORMANT			ADDRESS					
NO		213-12-5031			Susie Robbins			Star Route Box 638 church Creek Md. 21622					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</i> minutes													
DUE TO, OR AS A CONSEQUENCE OF (b) _____													
DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>END STAGE ENPHYSEMA, MALNUTRITION</i>													
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____								
22a I certify that (1) (this hospital) attended the deceased from 11/17, 1986, to 5/8, 1987, that (1) (we) last saw the deceased alive on 4/25, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated													
22b SIGNATURE <i>L.J. Egseder, III, M.D.</i>		22c DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d DATE SIGNED 5/11/87					
22e PHYSICIAN'S NAME (TYPE OR PRINT) L.J. Egseder, III, M.D.		22f ADDRESS Rt. 3 Box 106, Easton, MD 21601											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 5/11/87		23c. NAME OF CEMETERY OR CREMATORIAL St. Johns Churchyard		23d. LOCATION CITY OR TOWN Golden Hill Dor. Md.							
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME		25a. DATE REC'D. BY REGISTRAR MAY 18 1987			25b. REGISTRAR'S SIGNATURE <i>Lia Scidmore-Lindale</i>								
CAMBRIDGE MD.													

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be ~~mailed~~ within 24 hours after death. Please do be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked  show any injury, or other traumatic event, the same must be noted on one of the following lines.

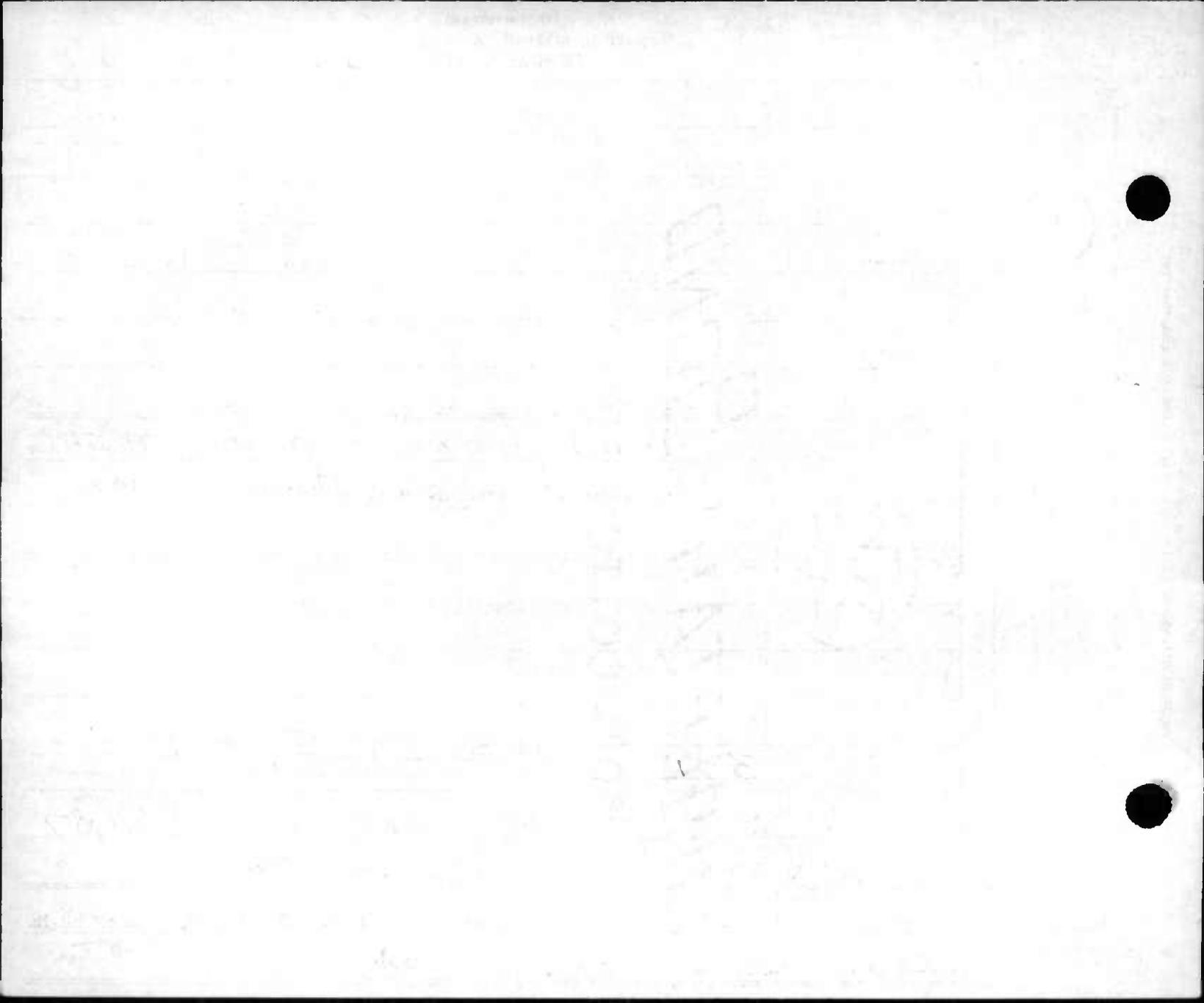


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Item 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Item 1 and 2 should be filled in by the funeral director.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8714381	REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
WILLIAM STEELE PHILLIPS												MAY 30, 1987				7:40 P M	
3. SEX <b>MALE</b>			4. RACE <b>WHITE</b>			5. DATE OF BIRTH MONTH <b>OCTOBER</b> DAY <b>31</b> YEAR <b>1914</b>			6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS MIN.		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>DORCHESTER COUNTY</b>								
10. CITY OR TOWN OF DEATH <b>CAMBRIDGE</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>DORCHESTER GENERAL</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>FARMER</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>AGRICULTURE</b>				MD.			
13a. STATE <b>MD</b>			13b. COUNTY <b>DORCHESTER</b>			13c. CITY OR TOWN <b>HURLOCK</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>MD RT. 331/21643</b>						
14. FATHER'S NAME FIRST <b>HOWARD</b> MIDDLE <b></b> LAST <b>PHILLIPS</b>			15. MOTHER'S MAIDEN NAME FIRST <b>LENA</b> MIDDLE <b></b> LAST <b>WATKINS</b>														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>-</b>			17. INFORMANT <b>DAVID E. PHILLIPS, CAMBRIDGE, MD 21613</b>			908 GLASGOW STREET								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Acute Myocardial Infarction			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost.			DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease			10 yrs											
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)											
21d. INJURY OCCURRED <b>WHILE AT HOME</b> <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>1983</b>			21f. LOCATION STREET <b>1983</b>			CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <b>3/30/87</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												21g. 5/30/87					
22b. SIGNATURE <b>Wm. Howard J</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>6/4/87</b>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Wm. H. Wood</b>			22e. ADDRESS <b>EASTON, MD</b>														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>6-2-87</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>EAST NEW MARKET CEM</b>			23d. LOCATION CITY OR TOWN <b>EAST NEW MARKET, DORCHESTER, MD</b>				COUNTY		STATE		
24. FUNERAL DIRECTOR NAME <b>ZELLER FUNERAL HOME, EAST NEW MARKET, MD</b>			ADDRESS			25a. DATE REC'D. BY REGISTRAR <b>JUN 10 1987</b>			25b. REGISTRAR'S SIGNATURE <b>Julia Scardon-Randall</b>								



053222

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon copy. Page 1 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 7 REG. NO. 14388				
1. DECEASED NAME (TYPE OR PRINT)				FIRST STEPHEN MIDDLE STEPHEN				LAST PIETROWSKI				2a. DATE OF DEATH 5-4-87	MONTH	DAY	YEAR	2b. HOUR 1:00 PM
3. SEX MALE		4. RACE CAU.		5. DATE OF BIRTH MONTH Aug. DAY 5, YEAR 1924				6. AGE (IN YEARS LAST BIRTHDAY) 62				IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.								
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cambridge House Nursing Hm.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) laborer				12b. KIND OF BUSINESS OR INDUSTRY general						
13a. STATE Maryland		13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE 21613 Cambridge, Md.						
14. FATHER'S NAME FIRST Tony		MIDDLE		LAST Pietrowski		15. MOTHER'S MAIDEN NAME FIRST Clara				MIDDLE				LAST Rachloski		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 213-22-9309				17. INFORMANT Cambridge, Md. 21613 Mrs. Niblett, Dept. of Soc. Services										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) OAT CELL CARCINOMA OF LUNG WITH DUE TO, OR AS A CONSEQUENCE OF (b) METATASIS TO LIVER AND BRAIN DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months.				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. 4 P.M. MONTH MAY DAY 19 YEAR 1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET 411 CITY OR TOWN 1987 COUNTY STATE												
22a. I certify that (I) (this hospital) attended the deceased from 4/11/1987 to 5-4-1987, that (I) (we) last saw the deceased alive on 4/11/1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did (did not) view the body after death.																
22b. SIGNATURE Michael A. Moskowicz		22c. DEGREE ID				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22d. DATE SIGNED 5-4-87						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael A. Moskowicz		22e. ADDRESS 21613														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 5/6/87		23c. NAME OF CEMETERY OR CREMATORIAL Our Lady of Good Counsel				23d. LOCATION COUNCIL, SECRETARY, DOR., MD.								
24. FUNERAL DIRECTOR NAME Curran Funeral Home, 308 High St. Cambridge, Md. 21613												25a. DATE REC'D. BY REGISTRAR MAY 08 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it may be filed in the funeral director's office. It should be detached for use as the burial-tranit permit. Then please remove carbon copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other unusual condition, the medical certifying physician should be consulted once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 87 14389															
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR											
CLARENCE			E.				PINK		MAY		18, 1987			M											
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8. CITIZEN OF WHAT COUNTRY?		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
MALE		CAUC.		FEB 3, 1891		96		NEW YORK		U.S.A.		DORCHESTER		CAMBRIDGE		CHELSEA DRIVE		EXECUTIVE		WOVEN WIRE PRODUCTS					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
MARYLAND		DORCHESTER		CAMBRIDGE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		CHELSEA DRIVE 21613		EDWARD		CARRIE		MOSHER		NO		214-07-7982		Cardiac failure		hikels			
18c. IMMEDIATE CAUSE (a)		18d. DUE TO, OR AS A CONSEQUENCE OF (b)		18e. DUE TO, OR AS A CONSEQUENCE OF (c)		18f. DUE TO, OR AS A CONSEQUENCE OF (d)		18g. DUE TO, OR AS A CONSEQUENCE OF (e)		18h. DUE TO, OR AS A CONSEQUENCE OF (f)		18i. DUE TO, OR AS A CONSEQUENCE OF (g)		18j. DUE TO, OR AS A CONSEQUENCE OF (h)		18k. DUE TO, OR AS A CONSEQUENCE OF (i)		18l. DUE TO, OR AS A CONSEQUENCE OF (j)		18m. DUE TO, OR AS A CONSEQUENCE OF (k)		18n. DUE TO, OR AS A CONSEQUENCE OF (l)			
18o. DUE TO, OR AS A CONSEQUENCE OF (m)		18p. DUE TO, OR AS A CONSEQUENCE OF (n)		18q. DUE TO, OR AS A CONSEQUENCE OF (o)		18r. DUE TO, OR AS A CONSEQUENCE OF (p)		18s. DUE TO, OR AS A CONSEQUENCE OF (q)		18t. DUE TO, OR AS A CONSEQUENCE OF (r)		18u. DUE TO, OR AS A CONSEQUENCE OF (s)		18v. DUE TO, OR AS A CONSEQUENCE OF (t)		18w. DUE TO, OR AS A CONSEQUENCE OF (u)		18x. DUE TO, OR AS A CONSEQUENCE OF (v)		18y. DUE TO, OR AS A CONSEQUENCE OF (w)		18z. DUE TO, OR AS A CONSEQUENCE OF (x)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										Urinary Retention due to prostatic hypertrophy															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
21g. I certify that (I) (this hospital) attended the deceased from <u>May 16 1987</u> to <u>May 18 1987</u> , that (I) <input type="checkbox"/> last saw the deceased alive on <u>May 16 1987</u> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did <input type="checkbox"/> not <input type="checkbox"/> view the body after death.		21h. SIGNATURE <u>Lewis M. Burdette MD</u>		21i. DEGREE <u>Lewis M. Burdette MD</u>		21j. ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		21k. DATE SIGNED <u>18/05/87</u>																	
22a. PHYSICIAN'S NAME (TYPE OR PRINT)		22b. ADDRESS		22c. DATE SIGNED		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE									
Lewis M. Burdette		4 Huron St Cambridge MD 21613		18/05/87		BURIAL		MAY 20, 1987 DOR. MEM. PK. CEM.		CAMBRIDGE DORCHESTER MD		BALTIMORE		MD		MD									
24. FUNERAL DIRECTOR NAME		308 HIGH ST., CAMBRIDGE, MD.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		CURRAN FUNERAL HOME		21613		MAY 21 1987		Julia Burdette		Baldado									

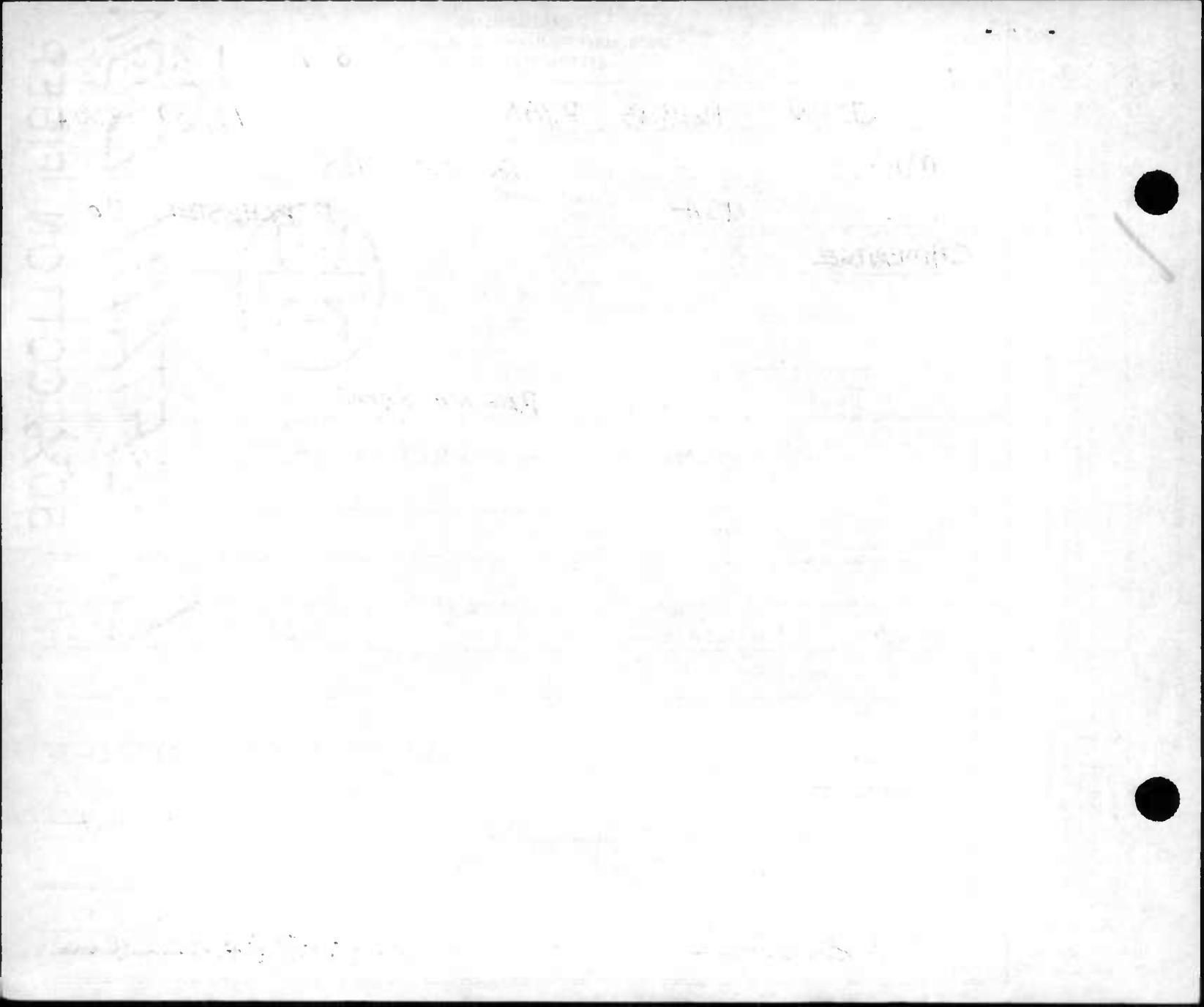


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										87	14390				
1. DECEASED NAME [TYPE OR PRINT]										2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
FIRST MIDDLE LAST JOHN HOPKINS RYAN										MAY 17, 87				8:10 AM	
3. SEX Male		4. RACE WHITE		5. DATE OF BIRTH MONTH JULY DAY 12 YEAR 18		6. AGE [IN YEARS LAST BIRTHDAY] 68		IF UNDER 1 YEAR YRS		IF UNDER 24 HRS MONTHS DAYS HOURS MIN.					
7a. BIRTHPLACE [STATE OR FOREIGN COUNTRY] BALTO. MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER Co MD.									
10. CITY OR TOWN OF DEATH CAMBRIDGE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER COUNTY HOSPITAL		12a. USUAL OCCUPATION 12b. KIND OF BUSINESS OR INDUSTRY DEPT. CHIEF WEST. ELECTRIC											
13a. STATE MARYLAND		13b. COUNTY DORCHESTER		13c. CITY OR TOWN CAMBRIDGE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE BOX 191A4 Rt. 3		21613					
14. FATHER'S NAME FIRST JOHN MIDDLE P. LAST RYAN		15. MOTHER'S MAIDEN NAME FIRST HELEN MIDDLE		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		17. INFORMANT WIFE REGINA RYAN		ADDRESS SAME AS 13							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEPATOCELLULAR CARCINOMA</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 days					
DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____															
DUE TO, OR AS A CONSEQUENCE OF (d) _____ (e) _____															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a. DATE OF OPERATION 4/30/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED EXPLORATORY LAP. B/L				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED [ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2]											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>4/28</u> , 19 <u>87</u> , to <u>5/17</u> , 19 <u>87</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>5/16</u> , 19 <u>87</u> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (I) <input type="checkbox"/> (we) did <input checked="" type="checkbox"/> (did not) view the body after death.															
22b. SIGNATURE <u>Hubert L. Fiery</u>		22c. DEGREE MD		22d. ATTENDING PHYSICIAN MD		22e. MEDICAL DIRECTOR MD		22f. STAFF PHYSICIAN MD		22g. DATE SIGNED 5/17/87					
22d. PHYSICIAN'S NAME [TYPE OR PRINT] <u>Hubert L. Fiery</u>		22e. ADDRESS 503 BYRN ST													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MAY 20, 1987		23c. NAME OF CEMETERY OR CREMATORIAL GLEN HAVEN MEM'L PARK		23d. LOCATION CITY OR TOWN GLEN BURNIE		COUNTY A.A.		STATE MD					
24. FUNERAL DIRECTOR NAME <u>John B. Boeger</u> ADDRESS SINGLETON FUNERL HOME, GLEN BURNIE, MD				25a. DATE REC'D. BY REGISTRAR MAY 19 1987		25b. REGISTRAR'S SIGNATURE <u>La Darden</u>									

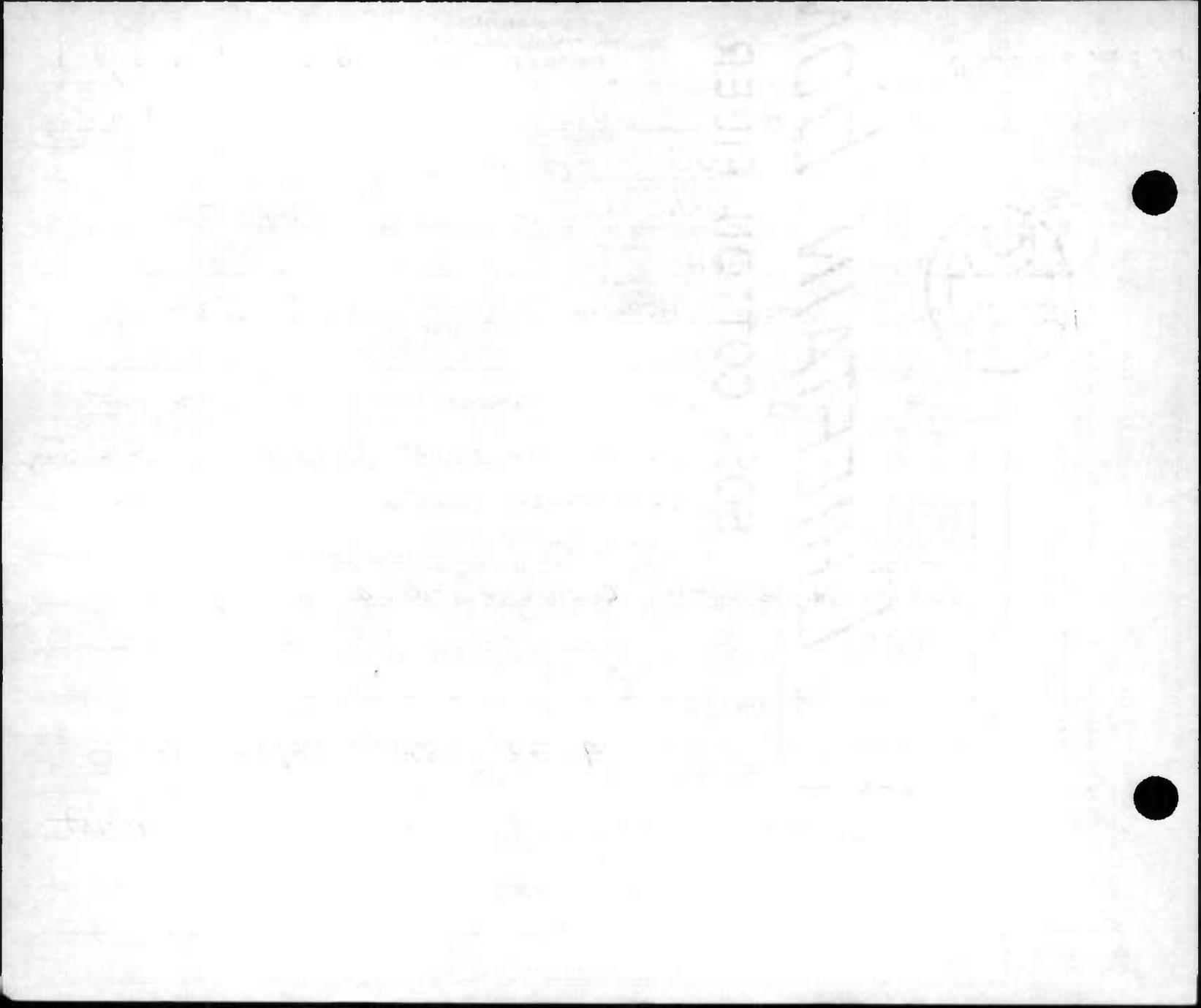


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be detached and used as the death certificate. Page 3 should be attached to the death certificate. Page 4 may be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked DEATH in Part 1, then the death certificate is for a death.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										87	14391	REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Ernie M Stokes						5/22/87			5	22	87	4:45 AM		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
m		CAUC		12 25 20			66			YRS	MONTHS	DAYS	HOURS	MIN.
BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Md		USA					DORCHESTER							
CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
CAMBRIDGE		D6H		100m operator			mfg.							
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13b. STREET ADDRESS / ZIP CODE				
Md		DORC		13c. CITY OR TOWN			RT 1 BOX 22 21643							
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		LAST		
Harry		McLane		Stokes			Xantippi					McWilliams		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. IF YES, GIVE WAR OR DATES		16c. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
YES		WORLD		217-12-4907			ROBERT STOKES			412 LINDEN AVE				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE										230 day				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) GENERALIZED ASCVD										4 yrs				
DUE TO, OR AS A CONSEQUENCE OF (c) DIABETES														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a														
PERIPHERAL NEUROPATHY, Coronary Heart disease class IV, OBS														
19a. DATE OF OPERATION 5/6/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED BPH		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that (I) this hospital attended the deceased from 5/7/24 to 5/22, 1987, that (I) we last saw the deceased alive on 5/21, 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) did (did not) view the body after death.														
22b. SIGNATURE Robert J. Fiery		22c. DEGREE MD		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 5/22/87							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		ADDRESS												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 5/24/87		23c. NAME OF CEMETERY OR CREMATORIAL Dor. Memorial Park, Cambridge Dor. Md.			23d. LOCATION CITY OR TOWN			COUNTY		STATE		
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME CAMBRIDGE MD.		ADDRESS		25a. DATE RECEIVED BY REGISTRAR MAY 27 1987			25b. REGISTRAR'S SIGNATURE Julia Deidone							



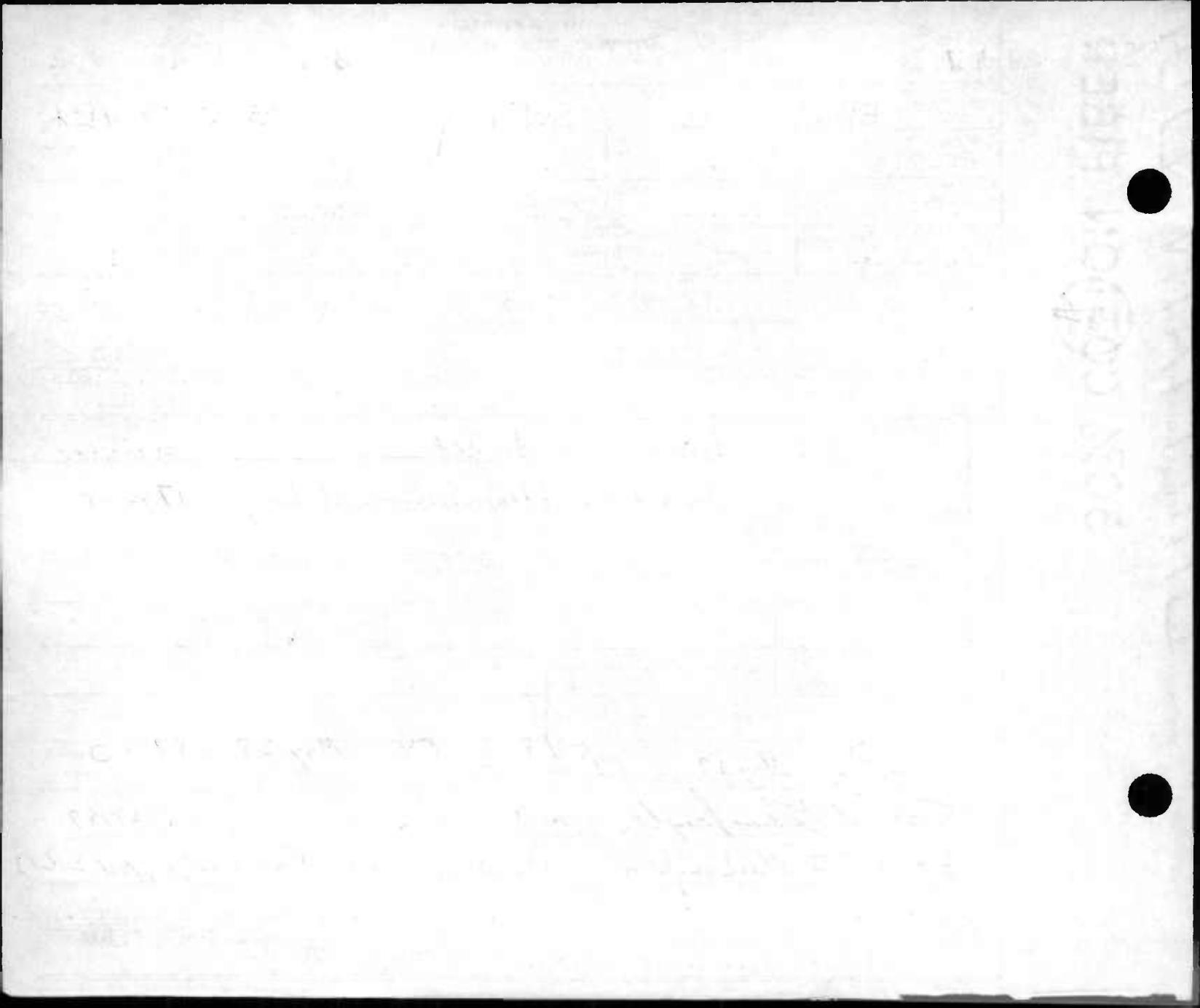
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in the presence of a physician.

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 3 and 4 may be filed within 72 hours after death.

IMPORTANT: If item 21 is marked on them, it shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	7	1	4	3	9	2					
										REG. NO.											
1 - STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT)				FIRST ETHEL		MIDDLE B		LAST BRADSHAW		2a DATE OF DEATH		MONTH		DAY		YEAR		2b HOUR	
Ethel						Swing		Swing				05		28		87		11 50 AM			
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR		IF UNDER 24 HRS							
FEMALE		CAU.		MONTH AUG. 20, 1906				80				MONTHS		DAYS		HOURS		MIN			
7a. BIRTHPLACE COUNTRY MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD													
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SPECIFICITY, GIVE STREET ADDRESS) CAMBRIDGE HOUSE NURSING HM.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) teacher				12b. KIND OF BUSINESS OR INDUSTRY school											
13a. STATE MARYLAND		13b. COUNTY DORCHESTER		13c. CITY OR TOWN CAMBRIDGE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE 807 Locust St., Cambridge 21613											
14. FATHER'S NAME FIRST G.		MIDDLE WINTHROP		LAST BRADSHAW		15. MOTHER'S MAIDEN NAME FIRST ETHEL				MIDDLE				LAST COOKE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-48-4377				17. INFORMANT (daughter) Cambridge, Md. 21613 ETHEL S. COX, 11 Buena Vista Rd.,															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		Respiratory Arrest				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Adenocarcinoma of Lung				17 years															
		DUE TO, OR AS A CONSEQUENCE OF (c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET				CITY OR TOWN		COUNTY		STATE							
22a. I certify that (I) this hospital attended the deceased from May 27, 1987, to May 28, 1987, that (I) we lost saw the deceased alive on May 27, 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) we did not view the body after death.																					
22b. SIGNATURE Edmund J. MacLaughlin		22c. DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22d. DATE SIGNED 5/28/87											
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Edmund J. MacLaughlin		22f. ADDRESS 10 Aurora St Cambridge, Md 21613																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial ===		23b. DATE 5/30/87		23c. NAME OF CEMETERY OR CREMATORIAL Old Trinity Church				23d. LOCATION CITY OR TOWN Cem., Church Creek, Dor., Md.													
24. FUNERAL DIRECTOR NAME CURRAN FUNERAL HOME 308 High St., Cambridge, Md. 21613		25a. DATE REC'D. BY REGISTRAR JUN 3 1987				25b. REGISTRAR'S SIGNATURE Julia Gordon Radke															

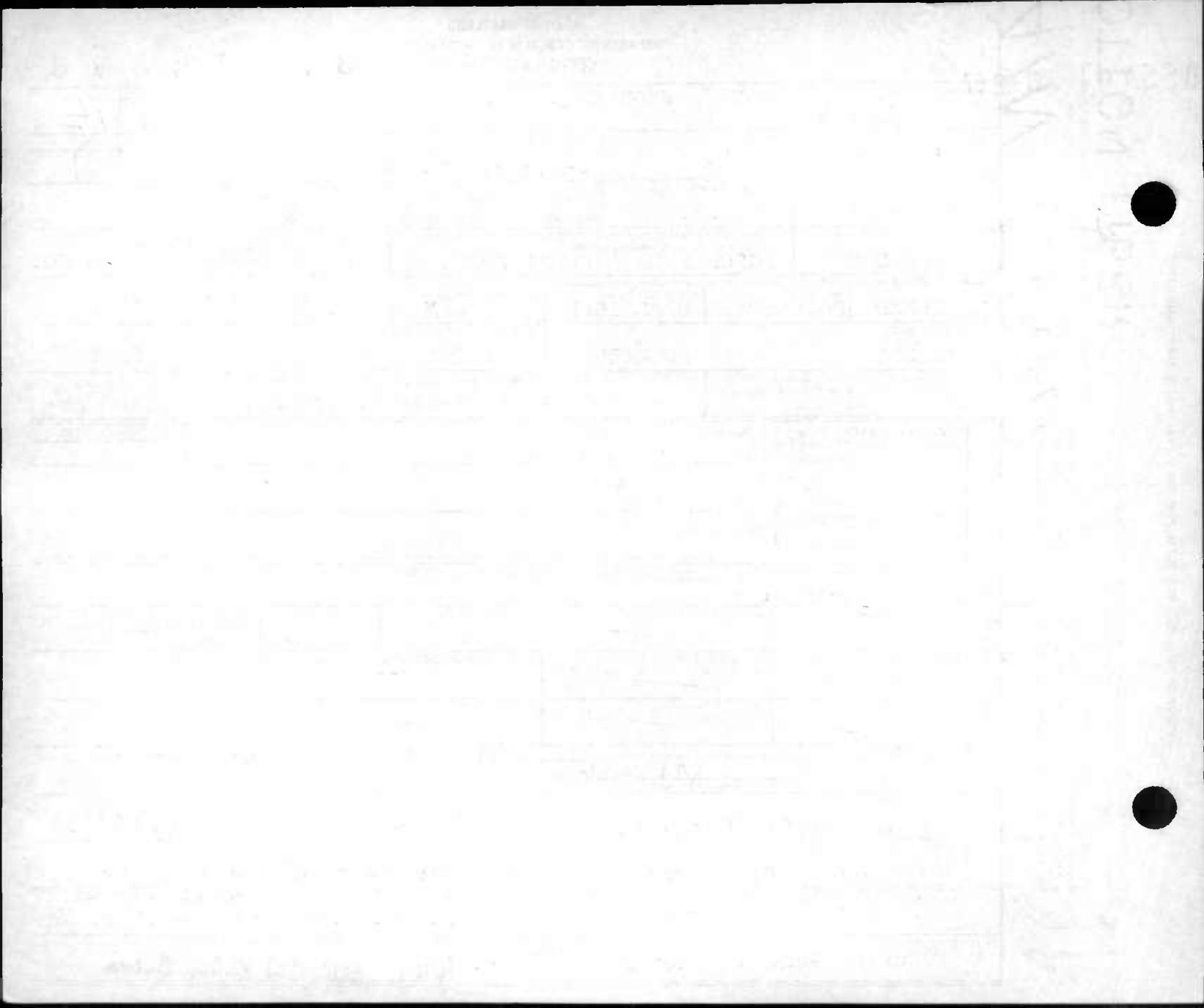


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IMPORTANT: If item 21 is marked other it shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
87 REG. NO. 14393													
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)				FIRST EULAH		MIDDLE S		LAST SHORTER		THOMAS	
2. DATE OF DEATH		MONTH		DAY		YEAR		2b HOUR					
5/26/87		17		17		PM		17					
3. SEX		4 RACE		5 DATE OF BIRTH		6 AGE		7 IF UNDER 1 YEAR		8 IF UNDER 24 HRS			
FEMALE		CAU.		MONTH April		DAY 30		YEARS 72		MONTHS DAYS HOURS MIN.			
7b. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH							
MARYLAND		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		DORCHESTER							
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
CAMBRIDGE		DORCHESTER GENERAL HOSP.		machine operator		Can Co.							
13a. STATE MARYLAND		13b. COUNTY DORCHESTER		13c. CITY OR TOWN CAMBRIDGE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Rt. 1 21613					
14. FATHER'S NAME FIRST ERNEST		MIDDLE		LAST SHORTER		15. MOTHER'S MAIDEN NAME FIRST SADIE		MIDDLE BELLE		LAST INSLEY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT SON		ADDRESS		13e					
NP		2;6-14-9488		Reginald E. Thomas, Jr., same as									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Arter M. I.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DOUE TO, OR AS A CONSEQUENCE OF (b) <u>COPD</u>													
DOUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <u>None</u>													
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>5/21/86</u> to <u>5/26/86</u> , that (I) (we) last saw the deceased alive on <u>5/21/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Urneeter MD</u>		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 5/26/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS <u>400 Aurora St Columbia</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		23b. DATE <u>5/28/87</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Dorchester Mem. Pk.</u>		23d. LOCATION CITY OR TOWN <u>Airey, Cambridge, Dor., Md.</u>		23e. COUNTY <u>21613</u>		STATE			
24. FUNERAL DIRECTOR NAME <u>Curran Funeral Home</u>		24b. ADDRESS <u>308 High St.</u>		24c. DATE REC'D. BY REGISTRAR <u>JUN 1 1987</u>		24d. REGISTRAR'S SIGNATURE <u>Julie Davidson-Landale</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certification must be signed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1 - FOR STATE REGISTRAR			2a DATE OF DEATH							2b. HOUR		
1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST		May 14, 1987			3:15AM	
Curtis			Thompson									
3 SEX			4 RACE			5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)			7 IF UNDER 1 YEAR MONTHS DAYS	8 IF UNDER 24 HRS HOURS MIN.
Male			White			MONTH DAY YEAR May 1, 1903		84				
7a BIRTHPLACE COUNTRY			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			MD	
Maryland			US					Dorchester Co.				
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY				
Cambridge			Dorchester General Hosp.			Water Co. Manager					21613	
13a STATE			13b COUNTY			13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS / ZIP CODE 403 Oakley Street	
Maryland			Dorchester			Cambridge						
14 FATHER'S NAME			FIRST MIDDLE LAST			15 MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)			16b SOCIAL SECURITY NO.	
Clifton			Thompson			Ida		NO			217-14-0138	
16c IMMEDIATE CAUSE (a)			16d DO TO, OR AS A CONSEQUENCE OF (b)			17 INFORMANT		17b ADDRESS			18 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HOURS	
PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)			CARCINOMA OF LUNG			Della M. Thompson Item # 13					DAYS	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			DO TO, OR AS A CONSEQUENCE OF (b)									
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) this hospital attended the deceased from 3/11/87 to 5/14/87, the (we) lost now the deceased died on 5/13/87, and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.												
22b. SIGNATURE David B. Stoeckle, M.D.			22c. DEGREE MD			22d. ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 5/15/87			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 5/16/87			23c. NAME OF CEMETERY OR CREMATORIAL Dor. Mem. Park			23d. LOCATION CITY OR TOWN Cambridge COUNTY Dor. Md.			
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME CAMBRIDGE, MD.			25a. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE MAY 19 1987									

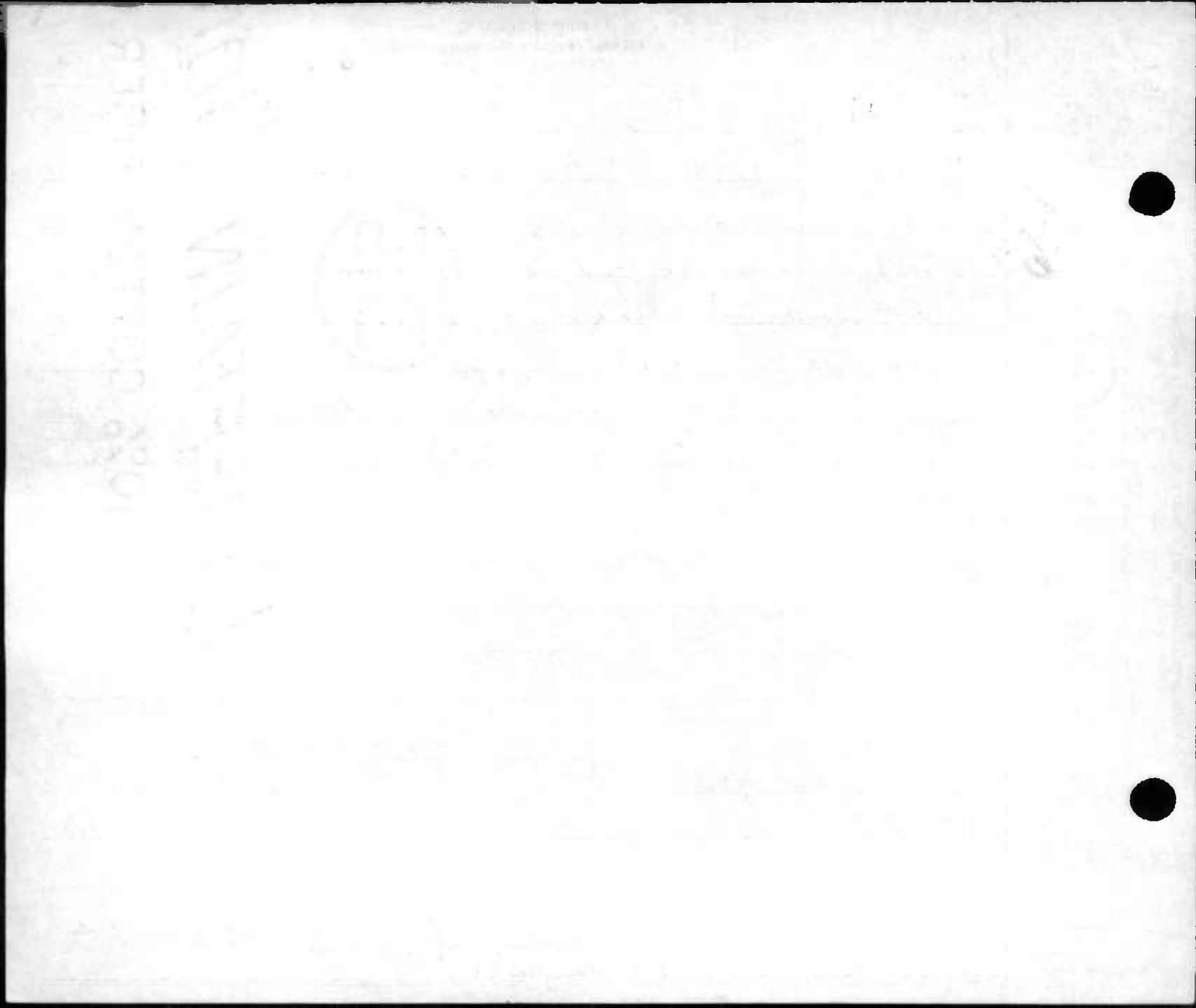


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper, page 2 should be filled in within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	7	1	4	3	9	5	
										REG. NO.							
1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		20. DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR	
		Phillip R. Todd									5/14/87		0256				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.					
Male		Black		3/19/25			62 YRS										
10. BIRTHPLACE COUNTRY		11. CITIZEN OF WHAT COUNTRY?		12. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			13. BALTIMORE CITY OR COUNTY OF DEATH										
Md.		U. S.					Dorchester										
14. CITY OR TOWN OF DEATH		15. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			16a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Cambridge		Dorchester Gen. Hospital			Laborer												
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE								
Md.		Dorchester		Cambridge					Box 58 Church Creek Md. 21622								
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		LAST						
Edward				Todd		Stella					Pritchett						
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH						
(YES, NO OR UNKNOWN)		216-16-7467			Judy Brown 1002 Washington St / 21613						ONE HOUR						
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>																	
DUE TO, OR AS A CONSEQUENCE OF (b) _____																	
DUE TO, OR AS A CONSEQUENCE OF (c) _____																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE						
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <u>5/13/87</u> , 19 <u>87</u> , to <u>5/13/87</u> , 19 <u>87</u> , that <input type="checkbox"/> (we) last saw the deceased alive on <u>5/13/87</u> , 19 <u>87</u> , and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) did <input type="checkbox"/> (did not) view the body after death.																	
22b. SIGNATURE <u>Michael D. Sykes</u>		22c. DEGREE M.D.			22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22e. DATE SIGNED <u>5/13/87</u>									
22f. PHYSICIAN'S NAME (TYPE OR PRINT)					22g. ADDRESS												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS			23d. LOCATION CITY OR TOWN		COUNTY	STATE							
Burial		5/19/87		Sojourner Wesley Ceme			Livers Rd. Dar.		Md.								
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE												
STewart Funeral Home		510 Washington St.			MAY 21 1987			Julia Deacon-Landale									

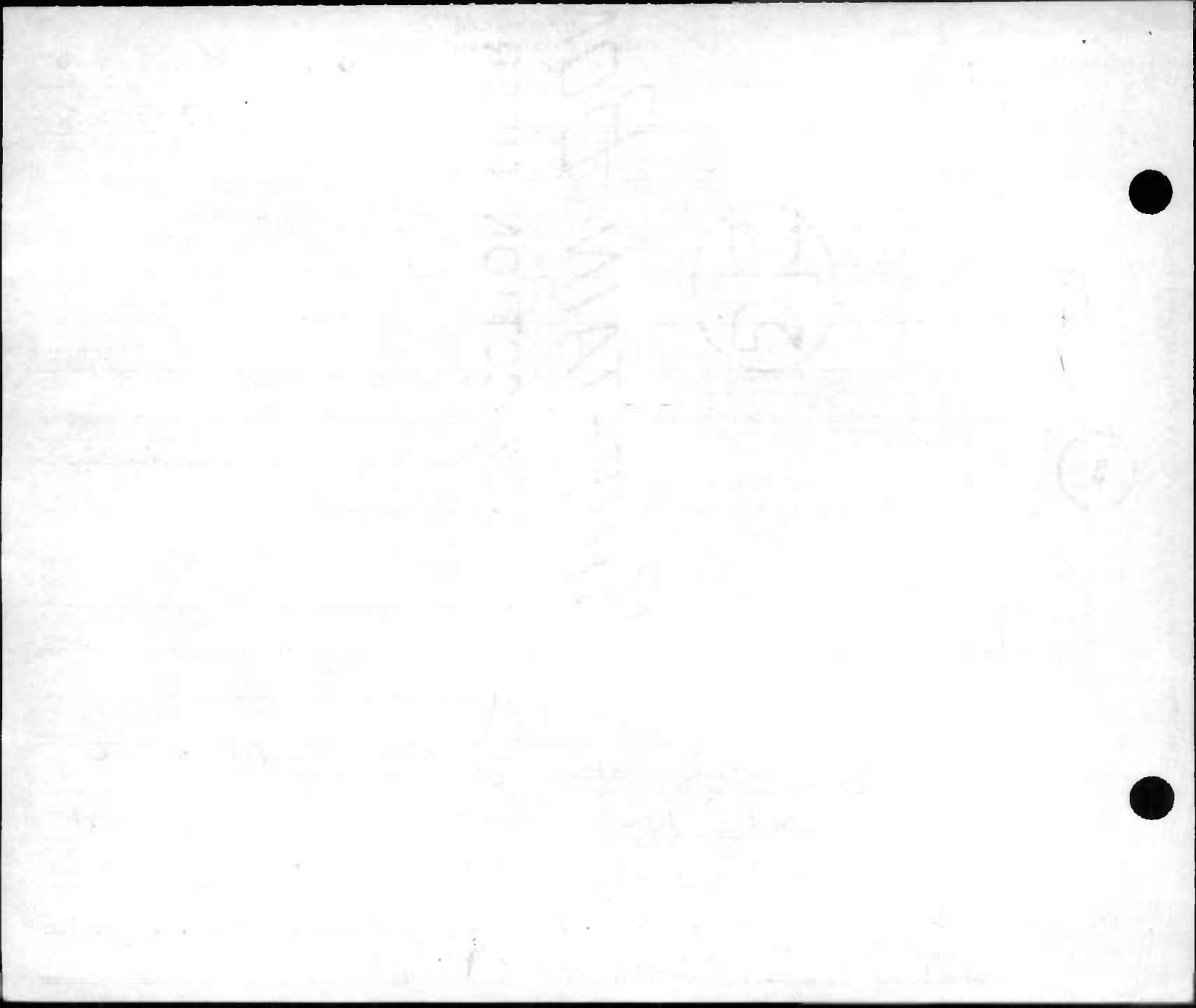


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it may be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal. If item 18 is marked, the medical certificate may be retained by the funeral director. If item 21 is marked, the medical certificate may be retained by the funeral director. Page 3 should be detached for use as the burial-travel permit. Then please remember to file this certificate in the death register.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other type of death, the medical certificate may be retained by the attending physician.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	7	1	4	3	9	6
										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			20. DATE OF DEATH MONTH DAY YEAR			2b. HOUR							
JAMES FRANKLYN TYLER						5 17 87			1205 AM							
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS					
Male		Cauc		8 17 08			78		YRS		MONTHS DAYS HOURS MIN					
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVERMARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER								
CITY OR TOWN OF DEATH CAMBRIDGE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic								
13a. STATE Maryland		13b. COUNTY Prince Geo.		13c. CITY OR TOWN Hyattsville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5408 20th Place		12b. KIND OF BUSINESS OR INDUSTRY Oil Burner					
14. FATHER'S NAME FIRST: Thomas		MIDDLE: E.		LAST: Tyler			15. MOTHER'S MAIDEN NAME Dora		16. PILLSBURY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. WW 2 578-07-1126			17. INFORMANT Mrs. Carol Robbins, Maryland 21613			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LUNG CANCER DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c))				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 mo				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. ASCD, ATRIUM FIBRILLATION																
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (1) (his hospital) attended the deceased from 5/16/87 to 5/17/87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (2) (we did) (did not) view the body after death.																
22b. SIGNATURE Hubert L. Flory		22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 5/17/87									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Hubert L. Flory		22e. ADDRESS 503 BYRN ST. CAMBRIDGE MD.														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 20, 1987			23c. NAME OF CEMETERY OR CREMATORIAL Md. Veterans Cemetery Cheltenham, P.C., Maryland		23d. LOCATION CITY OR TOWN COUNTY STATE									
24. FUNERAL DIRECTOR FRANCIS GASCH'S SONS FUNERAL HOME, P.A. 4739 Baltimore Ave., Hyattsville, Maryland										25a. DATE REC'D. BY REGISTRAR MAY 21 1987		25b. REGISTRAR'S SIGNATURE Julia [Signature]				



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 24. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1, 2, AND 3 COULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1, 2, AND 3 COULD BE USED AS A BURIAL TRANSIT PERMIT. AFTER DEATH, WITH THE STATE DIVISION OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 4397						
1- STATE REGISTRAR			2a. DECEASED NAME (TYPE OR PRINT)			LAST			2b. DATE KNOWN OF DEATH ESTIMATED		MONTH	DAY	YEAR	2d. HOUR		
Stewart Kenneth Willey									<input checked="" type="checkbox"/>		5/31	1987		M		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN				2c. DATE Pronounced Dead		MONTH	DAY	YEAR	2d. HOUR		
Male	White	July 21, 1962 24 yrs.							<input checked="" type="checkbox"/>		5/31	1987		M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH			2d. HOUR				
Easton, Md.			U.S.A.			<input type="checkbox"/> Separated			Dorchester			2d. HOUR				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			MD				
Rhodesdale			Rt. 1, Box 27			Electronics = Airpax Co.										
13a. STATE Maryland			13b. COUNTY Dorchester			13c. CITY OR TOWN Rhodesdale			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 1, Box 27			21659		
14. FATHER'S NAME FIRST			MIDDLE			15. MOTHER'S MAIDEN NAME FIRST			LAST							
E. Wallace Willey						Mary Louise Smith										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			Cambridge				
No			214-76-1889			Irene Willey, 412 Willis St., Md.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shotgun Wound of Head</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (10)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?										
									<input checked="" type="checkbox"/>			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR <b>XX</b> MONTH DAY YEAR 7:10 P.M. 5/31 1987			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
						subject shot										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home			21f. LOCATION STREET Rt. 1, Box 27, Rhodesdale,			CITY OR TOWN			COUNTY STATE Dorchester Co. Md.				
22. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> TITLE (SPECIFY) Resistant MEDICAL EXAMINER																
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. ADDRESS 111 Penn St.															DATE SIGNED 5/4/87	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE May 6, 1987			23c. NAME OF CEMETERY OR CREMATORIAL Brookview Cemetery			23d. LOCATION CITY OR TOWN Brookview, Dor., Maryland			COUNTY STATE				
24. FUNERAL DIRECTOR NAME Frampton-Hawkins Funeral Home, 216 N. Main			ADDRESS			25a. DATE REC'D. BY REGISTRAR MAY 12 1987			25b. REGISTRAR'S SIGNATURE Julia K. Smith							

zadanezenei hosszúság

A.C.U

az utolsó 2 hónapban

az xes, 1.38 m hosszú

az xes, 1.38 m

minőségi környezetben

minőségi környezetben

minőségi környezetben

szűrőkben

az xes, 1.38 m hosszú környezetben